THE HEALTH INSURANCE CERTIFICATE ACT OF 2003

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

ON

H.R. 2698

JULY 17, 2003

Serial No. 108–44

Printed for the use of the Committee on Energy and Commerce

Available via the World Wide Web: http://www.access.gpo.gov/congress/house

U.S. GOVERNMENT PRINTING OFFICE

88–431PDF WASHINGTON : 2003

For sale by the Superintendent of Documents, U.S. Government Printing Office
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THURSDAY, JULY 17, 2003

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:10 p.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Norwood, Fletcher, Brown, Waxman, Towns, Pallone, Eshoo, Strickland, Capps, and Dingell (ex officio).

Staff present: Nandan Kenkeremath, majority counsel; Yong Choe, legislative clerk; Jeremy Allen, health policy coordinator; Amy Hall, minority professional staff member; and Bridgett Taylor, minority professional staff member.

Mr. BILIRAKIS. Good afternoon. And I now call this hearing of the Health Subcommittee to order.

I would like to first thank our panel of witnesses who are joining us today. I am sure your insight will help us better understand the problem of the uninsured and how legislation like H.R. 2698 can help reduce the number of individuals without health insurance.

We all know the numerous problems that not having health insurance can cause. The uninsured tend not to access care as regularly, and when they do, they often do so in an inefficient manner such as through a hospital emergency room. What comes for individuals who didn't buy health insurance tends to be worse than they would be for individuals with health insurance.

Section 405 of the Congressional Budget Resolution for fiscal year 2004 included a $50 billion reserve fund over 10 years to be used to help provide health insurance to the uninsured. While $50 billion is not enough to guarantee health insurance coverage for the tens of millions of Americans without health insurance coverage, it is still, I am sure we would all agree, a significant sum of money and one we could do a lot of good with. There are many reasons why people find it difficult to buy health insurance either through their employer or on the individual market. And I am sure we will explore some of those causes today. I hope some of the discussion today centers on a May 2003 report by the CBO, Congressional Budget Office, that sheds some new light on the dynamics of the uninsured population.

Notably, CBO found that the majority of the uninsured are young, uninsured for only part of a given year and are either work-

ing or have a family member that works at least part-time or for part of the year. The premise behind H.R. 2698 is to help as many of these people as possible buy health insurance by providing subsidies to low-income individuals and families to help them with the cost of their insurance premiums.

Under the bill as currently drafted, individuals with incomes under $13,000 are eligible for a $1,000 health certificate which would gradually phaseout at $18,000. Families with incomes up to $25,000 would be eligible for a subsidy of $2,750 which would phaseout at $34,000. Under limited circumstances, eligible individuals would be able to use their certificate to help pay for their premiums associated with their employer-sponsored health insurance coverage.

H.R. 2698 also extends the authorization for funding first made available through the Trade Act of 2002 for State high-risk pools. And I would like to thank the gentleman from New York, Mr. Towns, for his good work in this area. High-risk pools help serve a small but expensive segment of the population, those people with high-risk conditions that cause them to be turned down for other forms of health insurance. Individuals who purchase insurance through a high-risk pool have access to a comprehensive health insurance product. While their premiums are higher than what they might pay were it not for their high-risk conditions, premiums are capped usually at no more than 150 percent of what a comparable plan might cost in an individual market.

This design structure means that by definition, high-risk pools lose money and need to be subsidized in order to function. Up until last year, States usually funded their high-risk pools through assessments on insurance carriers or through other State funding mechanisms. Now, many States will be eligible for Federal funding to help them establish new high-risk pools or to expand their ability to enroll new individuals into existing programs.

I make no claim that the bill before us is perfect or that it is in its final form or even that it must be the vehicle to help solve this problem, but it does say that this committee cares that so many Americans might not have adequate access to needed health care, and that hopefully, we can work together to try to solve this problem. That is why I opted to have a legislative hearing in this subject, so we can better understand the strengths and weaknesses of this approach and to hear of other possible approaches. I happen to think that this is a good bill and will help a lot of people buy health insurance that could not otherwise afford it. But again—and that this legislation will help the individual insurance markets function better, but again, I don't say this concept is the only way to go. I am open to whatever good ideas people might have to improve this legislation or to consider new ideas.

And with that, I yield to the gentleman from Ohio for an opening statement. The gentleman is recognized.

Mr. BROWN. I thank the chairman very much and welcome to our witnesses.

I appreciate the chairman's interest in covering the uninsured. There is clearly interest on this side in making major steps in covering the uninsured. There are no easy answers to this problem. And I commend both the chairman and Mr. Towns for taking the

initiative in developing a new coverage strategy for our consideration. I hope we will have the opportunity to hold additional hearings to consider other measures focusing on the uninsured.

H.R. 2461 is one of several coverage measures under the jurisdiction of this committee. Other bills, including ranking member Dingell's Family Care Act, offer viable options for expanding access to coverage. As Congress considers proposals like this bill and the President's tax credit approach that would subsidize the purchase of individual insurance policies, it would also be useful for the committee to address the notorious shortcomings of the individual insurance market. Barriers to access in the nongroup market are part of the problem. While it will be difficult to reform this market in a way that both protects individuals from discrimination and protects insurers from adverse selection, those reforms are absolutely necessary before it can reasonably expect the insurance market to be part of the solution. Today's hearing provides the subcommittee an opportunity to begin the discussion, and, as I said, I commend the chairman on his work in this critical area.

One of the Nation's longest running and most profound mistakes is our complacency about insurance access gaps. More than half the personal bankruptcies in this country result from catastrophic medical expenses. Coverage gaps are a drag on our Nation's potential. They compromise our public health goals, our families, our productivity, our collective prosperity. The chairman has offered a solution featuring insurance vouchers and appropriately targeting the largest group of uninsured Americans, low-income individuals and families.

Unfortunately, subsidies like this one hold little potential for reducing the number of uninsured. In fact, some think this could make the uninsured problem worse. The first problem is substitution. Most of the dollars invested in these vouchers would go toward reducing the cost of health insurance for individuals who are already insured. The bill's $49 billion investment health insurance certificates could reduce the number of uninsured by 1.2 million or about 3 percent as Mr. Greenstein said. That return simply doesn't justify the investment. The second problem is the proposal relies on individual coverage. The nongroup market is largely unregulated and notoriously inefficient and enormously expensive. In many States, nongroup premiums vary dramatically based on age and medical history. Insurers can refuse to cover some people entirely and can apply preexisting condition exclusions. While every individual who receives a voucher would have to supplement it to buy insurance, older less healthy individuals would have to pay far more than the voucher to get the coverage, if coverage is even offered to them. Older and less healthy individuals should be our first priority, particularly when our resources—according to Republican budget plans in large part because of a tax cut that has gone overwhelmingly to the wealthiest Americans—when resources are so limited. This proposal leaves them behind.

A related problem is the impact on group coverage both private and public. Because of the economies of scale and the broad pooling of risks, group coverage is inherently more cost-efficient and stable than individual insurance. That holds true whether you are comparing employer-sponsored health plans to individual insurance,

whether you are comparing Medicaid and SCHIP to individual insurance, whether you are comparing Medicaid to individual insurance, also known as Medicare+Choice. Administrative costs for Medicare and Medicaid are significantly under 5 percent. Administrative costs for group insurance plans are generally in the 12 to 15 percent range. Administrative costs for individual coverage can hit as high as 40 percent. If this bill were enacted, some employers would likely refrain from sponsoring health insurance. Others would drop the plans they sponsor now. Some States may even cut back on Medicaid and SCHIP.

This effect would likely be limited because the bill is modest in scope and relies on the appropriations process, and therein lies the fourth problem. If these subsidies come and go, so could health insurance access. Uncertainty about vouchers would undercut the ability of individuals and families to budget appropriately for future coverage needs. The last thing we want is for these subsidies to provoke substitution of individual coverage for public or private group coverage then have the subsidies disappear. It is my belief that building on successful group insurance models, Medicaid and SCHIP for instance, would better serve beneficiaries and taxpayers than the individual subsidy approach. It appears the dollars set aside in the budget resolution can be used to expand Medicaid and SCHIP, and, obviously, it is within our committee's jurisdiction to do so.

I appreciate, Mr. Chairman, your active involvement in the uninsured issue. I look forward to the discussion today. Hope we can have a wide-ranging discussion of various plans and yield back my time.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Dingell, ranking member of the full committee for an opening statement.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy in recognizing me.

I want to thank you, also, for holding the hearing today. I believe that the importance of this issue and the many different approaches to address it require a hearing so we can begin to reduce not only the number of uninsured but also to reduce the number of questions associated with how we should best do that. I commend you for putting forward the Health Insurance Certificate Act, which attempts to address the problems of the uninsured.

There is $50 billion available in fiscal year 2004 Budget Resolution for the uninsured, and I believe we should not let this opportunity go to waste. I do have some serious concerns about the legislation, however, as it is constructed. In particular, I worry that this approach does not get the most bang for the buck. In other words, it does not cover many of the uninsured for the amount it spends. As we hear from the witnesses today, estimates indicate that 89 percent of those who receive the certificate under this model will already have coverage. Thus for the $50 billion spent, it would reach only about 1.28 million individuals who previously did not have coverage. This is something like the average cost of $39,000 per newly insured person.

I am concerned about who will be able to receive coverage under the Health Insurance Certificate Act and what kind of coverage it

would be. There is nothing in this bill that guarantees any individual who gets a certificate will be able to use it or even that the coverage would provide the benefits needed. I fear that this legislation will wind up giving Federal dollars, primarily, to young, healthy individuals, leaving families and individuals who are older or in less-than-perfect health, the population most in need of assistance, I would note, out in the cold.

It is no surprise that my friends in the insurance industry would line up behind such a proposal. They do not want people with high risks in their health insurance plans. And if you look at the health plans of this country, most of them make their money not by the service they provide or by the efficiencies that they achieve, but rather by risk avoidance. I am sure that they will certainly take Federal funding to cure the healthy. I hope that we will see it differently and that we will provide assurances that the care goes to those most in need.

As a Nation it is our job to take care of all who are in need, not just to permit cream skimming and the care for the easiest, cheapest and the best who are seeking that service. I believe that a better approach would be one that builds off the existing system of public programs and employer coverage. Public programs already have an infrastructure in place and proven experience in serving not just the healthy, but also the most health-challenged and vulnerable individuals. Public programs also guarantee coverage to all who are eligible, coverage that is comprehensible, affordable and meets the very needs of families, and we know that they are cost effective.

We must also work to reinforce the existing system of employer coverage. We should not be setting up a system for healthy, low-cost individuals to flee to individual market policies leaving employers with the highest risks and spiraling costs. There are many employers out there who provide decent coverage for their workers and who want to continue to do so. There are also many who would like to but have serious difficulties in doing so. We need to shore up these employers. But unfortunately, the legislation before us does not do so and, in fact, may do some harm.

Any successful program will have to combine positive elements from a variety of approaches. Unfortunately, H.R. 2698 does need work in order to provide those kinds of approaches. It leaves those with the greatest health care on the outside looking in. I hope we can explore additional approaches to covering the uninsured in this committee before we act.

I look forward to hearing from today's witnesses. And I particularly welcome Mr. Jerry Shea from the AFL-CIO and Robert Greenstein who is the Executive Director of the Center on the Budget. Gentlemen, thank you for being with us, and thank you Mr. Chairman.

Mr. BILIRAKIS. And I thank the gentleman.

Dr. Fletcher?

Mr. FLETCHER. Thank you, Mr. Chairman, and thank you for holding this hearing and for your work on helping extend insurance and health care coverage for the uninsured.

When you look at the differences between morbidity and mortality and the number of studies, some in the older-age population,

across the board you see a substantial increase in morbidity and mortality, particularly, even hospitalized patients that have no insurance versus those who have no insurance. We commend your effort, Mr. Chairman, on working toward providing more insurance and decreasing the number of uninsured.

Reducing the number of uninsured in my State and the Nation is a large priority for me, and I am sure, as well, all of us. I am reminded that my bill, H.R. 660 the Small Business Health Fairness Act, that recently passed the House, if enacted and passed through the Senate, will go a long way toward helping small businesses provide their employees with health care coverage. It now makes sense that we turn our attention to workers and their families, providing them with the helping hand to purchase insurance coverage that they can barely afford now or even worse, go without all together.

In addition to helping those who have no insurance, I am pleased to see that this bill helps employees who currently have some health care coverage, giving those individuals the proper incentives and assistance to keep their current coverage because as we look across the market and across the Nation, we see an increasing number of uninsured because it becomes more and more difficult for individuals to even afford their share of the health care offered them. Overlooking this critical policy point would punish those who are already making sacrifices to purchase coverage for themselves and their families. I am pleased to see that the bill recognizes the importance of States high-risk pools and, accordingly, provides additional funding for those unable to purchase health care coverage in the traditional private market. We know that uninsured Americans face poor medical outcomes and in turn higher mortality, as I mentioned. A lack of coverage will also lead to less efficient use of health care services and facilities.

Those who may express concerns with the bill's cost need to understand that the uninsured often must seek care in the most costly settings, for example, the emergency room. And other unreimbursed costs that are absorbed by our hospitals and physicians are by necessity shifted to paying patients, raising health care costs for everyone. I look forward to the discussion on this important legislation and know there will be some good ideas presented about how we might improve this legislation.

And again I want to thank the chairman who put forth a good bill, and I commend him on his efforts.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Pallone for an opening statement?

Mr. PALLONE. Thank you, Mr. Chairman, for holding this hearing on what I consider an important issue, the uninsured. The country's woeful situation of the lack of access for health care coverage, which according to a recent IOM report reached 75 million uninsured Americans at any point during the year, is a problem that is not going away, especially in the light of our deeply troubled economy.

I know that the subcommittee is primarily evaluating 2698 today, and I just wanted to say that I'm afraid evaluating one proposal or focusing on what happens to piggyback off what the President requested, is really a nonstarter, in my opinion, when ad-

dressing the complex and tremendous crisis of both the uninsured and our flawed health insurance market.

In looking at H.R. 2698, I find that this means-tested program that provides subsidies to low- and low-middle-income families is inadequate, and I think derisive. It seems to me the problem of the uninsured is not fully addressed since the amount of subsidies being offered would never provide enough assistance to purchase skimpy coverage, let alone comprehensive coverage. Moreover, the bill is set up to provide subsidies to those who are already paying for health insurance coverage in some cases. And I am all for providing help to those who are underinsured, but if we are spending $50 billion over the next 10 years, and we are planning on trying the help the uninsured, then I think we need to evaluate some meaningful way to provide comprehensive, affordable coverage to those millions and millions of Americans who currently have no health insurance at all.

In addition to this bill today, we should be looking at a number of proposals. For example, if everyone likes tax credits so much, then we should consider tax credits that can be used toward purchasing employer-based health insurance that guarantees a basic package of benefits, or tax credits for hard-pressed small businesses to offer health insurance to their employees. I am in favor and have both introduced in the past and plan to reintroduce employer-mandate legislation that requires businesses of 50 employees and above to offer health insurance to their employees. Any of these types of initiatives that ensure a strong and stable system of employer-based health insurance should be discussed today if we intend to have a real discussion about providing health care protections to uninsured populations.

In addition, it is our responsibility to evaluate the expansion of government programs that have been successful in providing coverage to certain vulnerable pockets of population, such as the parents of children eligible for CHIP or the near-elderly population age 55 to 65.

I know that we need to deal with the problem with the uninsured, and I know it is a crisis, but I just have to say, Mr. Chairman, States are broke. Employers are shifting burdensome insurance costs to their employees, and I think we need to get away from this health certificate idea, the tax credits proposed by the President, because I don't really think they are a viable option, and there are a lot of other options that are viable that should be considered instead.

Thank you Mr. Chairman.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Mr. Towns, for an opening statement.

Mr. TOWNS. Thank you very much, Mr. Chairman.

I would like to begin by thanking you for holding this hearing. Health insurance safety nets help a small but critical segment of our population and their importance cannot be overlooked, and I want to thank you——

Mr. BILIRAKIS. Would the gentleman please continue. I would announce since we have been rudely interrupted, there are a series of six votes. And shortly thereafter, we are going to go into the

joint meeting with Prime Minister Tony Blair. So right after the six votes, we will come back and do the best that we possibly can.

Mr. TOWNS. Thank you, Mr. Chairman.

Even in the world's greatest health care system, sick people are often unable to access affordable health insurance. According to Communicating for Agriculture, 1 percent of our population has been deemed medically uninsurable. They cannot qualify for standard health insurance coverage because of preexisting health conditions, which makes it difficult to find affordable health insurance.

Health insurance safety nets are special programs created by State legislatures to provide needed coverage for people who are medically uninsurable. The way they work is fairly simple. The programs operate as State-created, nonprofit associations overseen by a board of directors which often include industry, consumer and State insurance department representatives. The board contracts with an established insurance company to collect premiums, pay claims and administer the program on a day-to-day basis. Currently 30 States have safety net plans, and approximately 153,000 people were covered by these plans last year. Safety net plans do not take the place of Medicare, Medicaid or any other State or Federal health care programs. They are largely temporary measures used to fill gaps in coverage; the average length of enrollment in such programs is approximately 30 months. Last year Congress recognized the value of health insurance safety nets and appropriated $100 million for State-based programs.

H.R. 1110, the State High-Risk Pool Funding Extension Act, currently with 41 cosponsors, extends initial Federal funding for an additional 5 years, thus allowing States to continue providing affordable health care to the population with the greatest need, including individuals with severe illnesses such as Parkinson's disease, diabetes and cancer.

This legislation also makes funds available for States without health insurance safety net plans to put such programs in place. As an original cosponsor, I am pleased that language extending the high-risk pool was included as part of H.R. 2698.

I look forward to the testimony of the witnesses today. I would like to conclude by saying although this might not be a perfect bill, it is a giant step and I am happy that we are moving in the right direction.

Thank you very much, Mr. Chairman, and I yield back on that note.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Let us see who is next, Ms. Capps.

Ms. CAPPS. Do we still have the option——

Mr. BILIRAKIS. Yes.

Mr. BILIRAKIS. Mr. Waxman.

Mr. WAXMAN. Thank you very much, Mr. Chairman. I am pleased you called this hearing, and I know we have a very distinguished panel that at some point is going to be able to tell us their views on this legislation and the problem generally of 41 million uninsured in this country.

It is a disgrace, it is shameful, but this isn't the first time we have said this. We've been saying that statement for almost 30 years. And what we have are so many millions of people in this

country without insurance. So if we are going to do something about the problem, we ought to look to see what we can do with very limited money and make sure we spend it wisely and also make sure we don't make the problem worse by encouraging employers to drop coverage.

My colleagues have said there are other alternatives. I want to repeat that there are other alternatives. We ought to make sure that we protect the coverage of public programs like Medicaid and SCHIP. And we should look at other ideas as well like the Family Care Act offered by Mr. Dingell. Another idea would be to buy into Medicare for spouses or persons who lose their jobs and eliminate the Medicare 2-year waiting period for disabled people.

Today, however, we are looking at only one option and that option has some problems with it. In my view, that option is subject to the vagaries of the appropriations process. And if we rely on an approach where we are looking for appropriations each year, we are starting out with a flat amount that is inadequate to purchase reasonable coverage and in future years we can expect that it is going to be further lagging behind the obvious increase in health care costs, which also is an approach that could well result in employers dropping group coverage and public programs being scaled back with the unfortunate effect of making the problem worse instead of better. It relies on the individual insurance market, which is already notorious for failure to provide assured and affordable coverage for people with or are likely to have health problems, and, by all estimates, is not very effective in reducing the number of the uninsured. But my point is not to be so critical of this one approach per se, but to point out that this subcommittee must surely provide equal attention to other approaches to covering the uninsured, which at least, in my view, are much more likely to make a meaningful contribution to addressing the problem. Shouldn't we owe the 41 million Americans without health insurance no less?

Mr. Chairman, I look forward to the testimony of the witnesses at some point today. Perhaps we ought to ask Prime Minister Blair not just to tell us of his ideas on intelligence and the Iraq nuclear weapons. Maybe we ought to get some of his ideas on health care. At least they cover all their people, which may not be the best approach for us, but they are doing something we haven't done. And that only shows in a glaring way how we have failed to treat all Americans with the dignity that they deserve.

Mr. BILIRAKIS. The Chair thanks the gentleman for his comments.

Ms. Eshoo for an opening statement. And then we will break for approximately an hour. I can only guess how long that will take. I apologize.

Ms. ESHOO. Good afternoon, Mr. Chairman, and thank you for having this hearing. And a warm welcome to the very distinguished panelists that are here to testify before us.

It has been stated that over 40 million Americans are without health insurance at any given time in our country. Given that we are the wealthiest Nation on the face of this earth, I think that that is a black eye for a great Nation.

So I look forward to what we are going to discuss today in the examination of at least one solution that is out there, and maybe

meld some ideas that members would have in order to make this legislation stronger and better, and really serve people well. The committee, I think, should pause before we actually shape a solution here, because I think we need to, after looking at the legislation—and I have met with the chairman and his staff on this, because I think we have the collective obligation to do something about this, but I think we need to take a step back and examine the fundamentals of the problem.

Who are the uninsured? What are their demographics? In order to best help people, we need to tailor a bill that will provide solutions that really fit their life circumstances. How are we going to ensure that any solution we provide, such as the health certificates that the chairman is proposing, won't diminish the coverage already provided by employers. We have to be careful to supplement current insurance options and not supplant them. I think it is very important that we determine whether the benefit being proposed is workable. Health certificates provide individuals with a specific amount of money to purchase insurance. In a way, it reminds me of Section 8 certificates at home. When people finally get that certificate, in an area where housing is a real premium in my district and certainly in the bay area, there is not housing to be found, even though you have the certificate in your hand. So how stable is the insurance market that this plan is reliant upon? We have to examine that.

I also think we should take into consideration what already is in place in our country. There is $50 billion, with a B, on the table. It is not enough to cover some of the 40 plus million in our country. How can we best, really get the best bang for the buck and use the $50 billion and optimize it?

So I don't know the answers to these questions, to all of them. I have some ideas about them. I do have a commitment to helping the uninsured. I really don't know how parents can wake up in the morning and know that if something happens or already has happened to their children that they don't have coverage. It is an undignified situation. We can do so much better in our country. We do have collective intellect here, in the private sector, and with those that are testifying here today to help shed some light on this issue. So I look forward to gaining even more knowledge today. I think as much as each one of us thinks we know, we could learn more.

I thank the chairman for raising the issue and for the witnesses who are here today.

Mr. BILIRAKIS. And I thank the gentlelady for her comments. I have heard some of them before, and I certainly agree with a large number of them.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Thank you Mr. Chairman: I want to commend you for holding this hearing and thank Chairman Bilirakis, Mr. Towns, Mr. Walden, and Mr. Fletcher for sponsoring H.R. 2698, the Health Insurance Certificate Act of 2003.

We are embarking on a bipartisan effort to assist uninsured Americans. Unfortunately, the problem of the uninsured in America has been a persistent one. For a few years, the strong economy and low health care cost inflation seemed to make a dent in the problem of the uninsured. Now I fear that rising health care costs and

a weaker economy jeopardize these gains. Employers, and particularly small businesses, face increasing pressures, which make provision of health insurance benefits difficult. We need to ease some of their pressures and ensure that the numbers of the uninsured always continue to decline.

H.R. 2698, the Health Insurance Certificate Act of 2003, is an income-related program designed to reduce the number of uninsured Americans by providing subsidies to low and low-middle income families for the purchase of health insurance coverage. In some cases, the bill will simply reduce the financial burden of those who have already been paying for health insurance coverage—a modest, but meaningful step. The bill also incorporates provisions of H.R. 1110, the State High Risk Pool Funding Extension Act of 2003. These provisions will help those who have historically had difficulty procuring coverage in the individual market.

Our legislation is a step in the right direction in addressing the plight of the uninsured. As you all know, the uninsured often have less access to care than those who are insured. They are more likely to delay obtaining care and frequently receive their health care services in a more costly emergency room setting. In addition, providers of health care are often uncompensated for the care that they provide to uninsured individuals. As a result, they often shift the cost of that care to other private and public payers.

This bill emphasizes a number of important values and marries smart policy with new resources. These values include individual choice of insurance plans, portability, a strengthening of private sector insurance mechanisms, and accountability. I know the bill won't solve all the problems of the uninsured but it will make a difference.

Let me stress: today's hearing is meant for us to explore this issue carefully. I remain open to good ideas and suggested ways to improve this legislation. However, the amount of money we can spend to address this problem this year is set by the budget agreement. So let's work within those parameters to produce the best bill possible.

I would like to thank all of today's witnesses for lending us their expertise on this matter. This issue may be one of the most important health care matters that we consider this Congress. It would be a shame if we didn't find a way to legislate some solutions to this pressing problem.

Mr. BILIRAKIS. Well, we are going to break now. And again, I apologize in advance, but probably an hour or so. Give you a chance to grab a bite to eat or whatever.

[Brief recess.]

Mr. BILIRAKIS. Our panel today consists of Dr. Donald A. Young, President of Health Insurance Association of America; Dr. John C. Nelson, President-Elect and Executive Committee Member of the American Medical Association; Mr. Gerald M. Shea, Assistant to the President for Government Affairs, American Federation of Labor and Congress of Industrial Organizations, better known as AFL-CIO; Ms. Dede Spitznagel, Executive Vice President of Healthcare Leadership Council on behalf of the Coalition for Affordable Health Coverage; and Mr. Robert Greenstein, Executive Director of the Center on Budget Policy Priorities.

Mr. Shea is not back yet. Well, all right. Well, gentlemen your written statements are a part of the record, and I apologize very much for not only the delay, but not having more members here. But that is the way it is up here. They just come and go. It is a very busy place. Your written statements are a part of the record, and we hope—what in the world is going on now?

I believe that is recess subject to the call of the Chair. And I will place the clock at 5 minutes, but if you are on the roll or something of that nature, I will certainly allow you some lead time.

Dr. Young—again thanks to all of you for being here and your understanding and patience.

Please proceed sir.

STATEMENTS OF DONALD A. YOUNG, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA; JOHN C. NELSON, PRESIDENT-ELECT AND EXECUTIVE COMMITTEE MEMBER, AMERICAN MEDICAL ASSOCIATION; GERALD M. SHEA, ASSISTANT TO THE PRESIDENT FOR GOVERNMENT AFFAIRS, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS; DEDE SPITZNAGEL, EXECUTIVE VICE PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL, ON BEHALF OF COALITION FOR AFFORDABLE HEALTH COVERAGE; AND ROBERT GREENSTEIN, EXECUTIVE DIRECTOR, CENTER ON BUDGET AND POLICY PRIORITIES

Mr. YOUNG. Chairman Bilirakis and members of the committee, HIA appreciates this opportunity to discuss your efforts to make health insurance coverage more affordable for low-income Americans.

In 1998 HIA Board of Directors formally adopted a comprehensive set of public policy recommendations, known as InsureUSA, to expand access to affordable health insurance coverage for all Americans. This initiative became a key legislative priority for our association. A summary of the InsureUSA proposal is attached to my testimony.

As the proposed Health Insurance Certificate Act of 2003 recognizes, the best way to reduce the number of the uninsured is to start with low-income individuals and their families. Over half of the uninsured live in families with incomes less than two times the Federal poverty level. Low-income individuals are less likely than others to have access to employer-sponsored health benefits, and when they are offered coverage at work, are more likely to turn it down. When asked, they consistently cite the cost as the primary reason for declining coverage. To make health care coverage affordable for all Americans, we must provide a meaningful subsidy to those who do not have the income to buy it on their own.

I am pleased to support H.R. 2698. This proposed legislation is consistent with HIA's InsureUSA proposal, which calls for providing direct financial subsidies through certificates, vouchers or refundable tax credits to the working poor to help them buy into the same private health insurance programs serving their neighbors and coworkers. We are particularly pleased that the subsidies may be applied toward the purchase of employer-subsidized coverage. Roughly one out of every five nonelderly uninsured individuals has been offered employment-based coverage but turned it down. Where employer-subsidized coverage is available helping uninsured individuals take advantage of it is a common sense way of expanding coverage. Requiring health insurance certificates to be used toward the purchase of plans that meet the Health Insurance Portability and Accountability Act of 1996 definition of credible coverage will ensure that the coverage obtained will be a primary health plan and not a limited-benefit hospital indemnity or other supplemental plan. Eligible individuals offered health benefits at work will be able to apply their certificate toward their employer's health plan without placing complex and burdensome requirements on employers. Other eligible individuals will be able to shop for the coverage that best meets their needs and the needs of their families just like any other consumer.

We are pleased to see that this proposal includes additional Federal funding for State-sponsored high-risk pools. Well-managed high-risk pools have proven to be an effective mechanism for ensuring access to health insurance coverage for individuals with serious medical conditions and do so without disrupting the private individual health insurance market on which millions of other consumers depend.

We welcome your efforts to help low-income Americans more easily afford private health insurance coverage. We strongly support the proposed Federal financial assistance for State high-risk pools. We would welcome the opportunity to work with you and your staffs in this effort and in future efforts to address the needs of the uninsured.

Thank you, Mr. Chairman.

[The prepared statement of Donald A. Young follows:]

PREPARED STATEMENT OF DONALD A. YOUNG, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

INTRODUCTION

Chairman Bilirakis and members of the committee, HIAA appreciates this opportunity to discuss your efforts to make health insurance coverage more affordable for low-income Americans. HIAA is the nation's most prominent trade association representing the private health care system. Our nearly 300 members provide health, long-term care, dental, disability, and supplemental coverage to more than 100 million Americans. Our members also provide stop-loss coverage to employers sponsoring self-funded health benefit plans, and reinsurance coverage to other health insurers. In addition, we are the nation's premier provider of self-study courses on health insurance and managed care.

HIAA has long been concerned about the growing number of uninsured Americans; we believe this is one of the most important health policy challenges facing the nation. The nature of this challenge is well understood. Research consistently demonstrates that the primary reason more than 41 million Americans lack health insurance coverage is that they simply cannot afford it. Any meaningful expansion of coverage must, of necessity, address the underlying issue of affordability. For most of the uninsured, for whom limited income is the primary barrier to coverage, this means someone else must help pay for the coverage they need. Of course, while we are focusing right now on the needs of the uninsured, it is important to remember that cost is an issue for everyone—anything we can do to help control the rising cost of health care will ultimately make health insurance more affordable for everyone.

Back in 1998, HIAA established a task force of experts from member companies to develop a new association policy on how best to extend health insurance coverage to more uninsured Americans. This task force developed a comprehensive set of public policy recommendations, known as InsureUSA, for guaranteeing access to affordable health insurance coverage to all Americans. The HIAA Board of Directors formally adopted InsureUSA in May of 1999. This initiative became a key legislative priority for our association, and we actively promoted it in the media and in a variety of public policy forums.

Early in 2002, HIAA formed a new Task Force on the Uninsured to review HIAA policy on the uninsured and make any adjustments necessary to reflect changes in the environment since 1999. We were pleased to find that the original InsureUSA proposal had stood the test of time quite well; only relatively minor fine-tuning was needed. The refinements proposed by the new task force were accepted, and HIAA's commitment to this issue, were reaffirmed by the Board of Directors in October of last year. A summary of the InsureUSA proposal is attached.

As the proposed "Health Insurance Certificate Act of 2003" recognizes, the best place to start reducing the number of uninsured is with low-income individuals and their families. The greatest number of the uninsured fall within this population segment, and they are also the ones who need help the most. Over half the non-elderly uninsured live in families with incomes below two times the federal poverty level. Low-income individuals are less likely than others to have access to employer-sponsored health benefits, and when they are offered coverage at work, are more likely to turn it down. When asked, they consistently cite cost as the primary reason for

declining coverage. Low-income families face many competing financial demands. All too often, there simply isn't enough income left over to pay for health insurance. If we are ever to make significant headway towards making health care coverage affordable for all Americans, we must provide a meaningful subsidy to those who do not have the income to buy it on their own.

DETAILS OF THE PROPOSAL

I am pleased to support H.R. 2698 as it is broadly consistent with HIAA's InsureUSA proposal. HIAA strongly supports federal financial assistance for the working poor to help them buy the health insurance coverage they need. A key component of InsureUSA calls for providing direct financial subsidies (i.e., certificates/vouchers or refundable tax credits) to the working poor to help them buy into the same private health insurance programs serving their neighbors and coworkers.

We are particularly pleased to note that the subsidies provided by H.R. 2698 may be applied towards the purchase of employer-subsidized coverage. This feature, which is also part of InsureUSA, is vital. Roughly one out of every five non-elderly uninsured individuals has been offered employment-based coverage, but turned it down;[1] where employer-subsidized coverage is available, helping uninsured individuals take advantage of it is a common-sense way of expanding coverage. It is also very important to avoid undermining the employment-based health insurance system; after all, almost nine out of every ten Americans with private health insurance is covered through that system. The employment-based health coverage—currently covering more than 160 million non-elderly Americans—is the most efficient mechanism for covering workers and their families, and should remain a key component of our health insurance system.

While including individuals offered coverage at work within the scope of the subsidy might seem expensive to some, we believe it to be a valuable long-term investment. For those who are currently uninsured, helping pay for the employee's share of the premium will almost always be less expensive than providing public coverage. Allowing the subsidy to help other low-income workers, who have already made the decision to participate in employer-sponsored coverage, is no waste of federal resources; by helping those workers who are least able to deal with the ever-rising cost of coverage, it is a common-sense way to help stabilize the system and forestall further erosion of coverage. As you continue to refine the proposal, we would encourage you to make every effort to avoid inadvertently undermining the efforts employers are making to provide health benefits to workers and their families.

Allowing health insurance certificates to be used towards the purchase of plans that meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) definition of "creditable coverage" strikes an appropriate balance, allowing for consumer choice and flexibility, while still ensuring that the funds will go towards the purchase of primary health coverage. Eligible individuals offered health benefits at work will be able apply their certificate towards that health plan—the same health plan used by their higher-wage coworkers—without placing complex and burdensome requirements on employers. Other eligible individuals will be able to shop for the coverage that best meets their needs and the needs of their families—just like any other consumer. At the same time, the HIPAA requirements will ensure that the coverage obtained will be a primary health plan, and not a limited benefit, hospital indemnity, specified illness or other supplemental benefit policy.

We are also pleased to see that this proposal includes additional federal funding for state-sponsored high-risk pools—an additional $35 million for fiscal year 2004, and $75 million annually for fiscal years 2005 through 2009. Well-managed high-risk pools have proven to be an effective mechanism for ensuring access to health insurance coverage for individuals with serious medical conditions, and do so without disrupting the private, individual health insurance market on which millions of other consumers depend. Federal support for these risk pools is another key element of InsureUSA.

POTENTIAL REFINEMENTS

Eligibility for the H.R. 2698 certificates is limited to individuals who are not eligible for public coverage—for instance, low-income singles or childless couples who are not elderly or disabled. We would suggest that you consider expanding eligibility to include all those who are not enrolled in public programs. As it stands, individuals or families who qualify for Medicaid or S-CHIP but who, for whatever reason, have

[1] Peter J. Cunningham, Elizabeth Schaefer, and Christopher Hogan, *Who Declines Employer-Sponsored Health Insurance and is Uninsured? Center for Studying Health System Change,* Issue Brief Number 22, October 1999.

chosen not to enroll are not eligible for a health insurance certificate. However, many eligible individuals may not enroll in public programs such as Medicaid and S-CHIP due to a perceived stigma. Providing the certificate as an alternative has the potential to help some of these individuals who cannot be reached—or simply do not wish to be served—through public programs. Since the value of the certificates is significantly less than the value of Medicaid or S-CHIP, those who elect the certificates would actually be choosing a coverage option involving lower federal expenditures.

H.R. 2698 also applies an asset test; it bases eligibility not just on income, but on how much an individual owns as well. Asset testing is important when providing Medicaid coverage to seniors, where retirees who need long-term care services and have significant assets might otherwise be tempted to limit their income to qualify for Medicaid coverage while still preserving their assets. Individuals in a long-term care facility present a special case regarding income. Once the monthly facility fee is paid for room and board, they have relatively few out-of-pocket expenses, and can afford to minimize their realized income. Fewer non-elderly individuals will combine very low incomes with significant assets. We would urge you to consider carefully whether such an asset test is cost-effective with a much younger population. Administering an asset test will complicate the program, and may well cost more than it saves.

You may also want to consider whether the size of the subsidy, when used in the individual market, should vary by age. Health care needs and in turn, the cost of health care coverage, rise significantly with age. A fixed certificate amount will constitute a proportionately larger subsidy for younger individuals, and cover a smaller percentage of the cost of coverage for older individuals. There may be some justification for providing an additional incentive to young adults, because they are more likely to be uninsured than any other demographic group. Nonetheless, given the rapid increase in costs with age, we believe it may be appropriate for the dollar value of any certificate or credit to increase as well. Balancing the need younger adults have for additional encouragement to buy coverage against the needs of older adults facing larger premiums makes for a difficult trade-off—particularly during a time of limited budgets.

CONCLUSION

We welcome your efforts to help low-income Americans pay for the health insurance coverage they need. HIAA strongly supports direct federal financial assistance for the working poor to help them buy the health insurance coverage they need We believe that subsidizing the cost of private coverage is the most appropriate way to expand coverage for the working poor, and that this must be done in a way that does not undermine the employment-based system of coverage on which over 160 million non-elderly Americans depend. We also strongly support federal financial assistance for state high-risk pools, which provide a vital safety net for individuals with serious health conditions.

We would welcome the opportunity to work with Members and their staffs in this effort, and in future efforts to address the needs of the uninsured.

INSUREUSA

COVERING AMERICA'S UNINSURED

Covering the Uninsured: HIAA's InsureUSA Proposal

Tens of millions of Americans still lack health insurance. To solve this enormous problem, Congress must act to help these Americans afford the health care coverage that they, and their families, need. HIAA's InsureUSA proposal (www.insureusa.org) offers a series of practical initiatives that would provide coverage for most of the nation's uninsured.

The time is ripe for action. The number of uninsured Americans grew steadily during most of the 1990's. While there was a two-year hiatus at the peak of the economic expansion, this was a brief pause in a steady trend that had lasted more than a decade. The growth in the uninsured has resumed with the current economic downturn. According to the U.S. Census Bureau, over 41 million Americans have no health insurance coverage.

To increase coverage, health insurance must be more affordable for more Americans. The main reason that Americans are uninsured is because they cannot afford health insurance coverage. Many well-intentioned attempts at insurance market reform have had the effect of increasing the cost of coverage and increasing the net

number of individuals without health insurance. Reforms, therefore, should both reduce the costs of health insurance and provide financial support for those who otherwise cannot afford coverage.

Multifaceted problem requires multifaceted approach. While affordability is the primary reason people lack health coverage, the uninsured have many faces. Rather than advocating a singular approach to insuring more Americans, we are advocating a 5-point program designed to attack the underlying reasons that people are uninsured.

A strong, vibrant private health insurance market should remain a cornerstone of our health care system. Expanded coverage must be achieved through means that do not threaten the coverage of other Americans or damage the existing private market. Competitive markets remain the most efficient and responsive mechanisms to provide consumers with coverage. Regulations that stifle innovation, flexibility and responsiveness to consumers should be strongly discouraged. For example, nothing in the proposal should be interpreted as favoring public coverage over private or as requiring health insurers to operate in markets in which they have chosen not to.

Reforms should make health coverage more affordable within the context of the employment-based private health care system, rather than destroying it. Nine in every 10 Americans with private health coverage get their health insurance through their employer. While the percentage of Americans with employment-based health coverage has declined somewhat in the wake of the recent economic slowdown, steady increases in coverage during most of the 1990s demonstrate the strength and resiliency of this system.

The new initiative should be financed with broad-based funds. Rather than recommending specific sources to finance this series of initiatives on the uninsured, HIAA recommends that funding decisions be left to state and federal policymakers. Policymakers should be encouraged to finance these proposals with broad-based funding sources. For instance, stable, on-going funding is critical to the success of any risk pool. Policymakers should consider general revenues, as well as state funds related to health (such as tobacco-related recoveries) as possible financing sources.

KEY ELEMENTS OF INSUREUSA

The InsureUSA proposal has 5 key components:

- Extending the safety-net for Americans living below the federal poverty level
- Giving the working poor the help they need to buy their own coverage
- Guaranteeing access to coverage for uninsurable individuals through broad-based funding for state high risk pools
- Encouraging greater coverage for individuals and small businesses through enhanced tax incentives
- Extending and enhancing Archer Medical Savings Accounts (MSAs)

I. COVERING VERY LOW-INCOME INDIVIDUALS

Conceptual approach: Extend the current social safety net obligation currently fulfilled by Medicaid to include all adults below 100% of the federal poverty level, regardless of family structure. Medicaid, the joint state-federal program designed to provide health insurance coverage to low-income Americans, does not extend coverage to all poor people. For example, married couples without children and men are generally not eligible for Medicaid coverage unless they are disabled. A government-sponsored program is proposed based on the assumption that individuals with family incomes below 100% of the federal poverty level have at best a tenuous connection with the work force (only 17.5% of non-elderly Americans in this income range have employment-based coverage).

Target population: Individuals and families with incomes below 100% of the federal poverty level who are not eligible for other federal or state subsidized health insurance coverage such as, but not limited to, Medicaid, Medicare or the Children's Health Insurance Program (S-CHIP).

Key elements of the proposal:

- Expansion of public program to provide health insurance to all individuals with incomes below 100% of poverty.
- Funding and structuring program are both fundamentally government responsibilities.
- Joint federal/state funding and program structure would be based on the S-CHIP program.
- States would be given significant flexibility with regard to coverage, benefits and program structure, as in the current Health Insurance Flexibility and Accountability (HIFA) demonstration initiative.

- States would be encouraged to use program funds to subsidize coverage under private employer-sponsored health plans for poor individuals eligible for such plans.

II. COVERING THE WORKING POOR

Conceptual approach: Subsidize the cost of private health insurance coverage for the near poor and working poor. Subsidized private coverage is proposed because this population segment largely consists of low-income working individuals who in many cases have access to employer-sponsored coverage (45% of non-elderly Americans with family incomes between 100-200% of the federal poverty level have employment-based coverage) and it is neither necessary nor desirable to replace private coverage with a government-sponsored program. The subsidy should be large enough to make coverage substantially more affordable for low-income individuals, but should not be so large as to encourage over-insurance. Because the cost of coverage varies significantly by age, family size and geographic location, it is critical to provide a subsidy that is equitable for individuals in different situations.

Target population: Individuals and families with incomes between 100% and 200% of the federal poverty level who are not eligible for current subsidy programs (e.g., Medicaid, Medicare or S-CHIP).

Key elements of the proposal:

- A refundable tax credit or direct federal voucher provided to individuals with incomes between 100% and 200% of poverty based on taxable income.
- If eligible individuals have access to an employer-sponsored plan, the credit or voucher would be used for the employee contribution.
- If no employer-sponsored plan is available, then the credit or voucher may be used towards any coverage meeting the Health Insurance Portability and Accountability Act (HIPAA) definition of "creditable coverage" for which the individual is eligible.
- If a tax credit is used:
  - It should be equal to 60-75% of the premium. A percentage of premium credit allows for variations in cost by age, family size and location.
  - The credit should be refundable, in order to help low-income taxpayers.
  - Ways to make the credit advancable should be explored.
- If a voucher is used:
  - The voucher amount should be based on an objective measure of the cost of providing health benefits, and should represent roughly 60-75% of the cost of coverage (e.g., equal to 75% of the national average Federal Employee Health Benefit Plan (FEHBP) premium).
  - The voucher should be adjusted for geographic and demographic variations in cost.
  - The voucher should be redeemable by health plans for actual premiums up to the full face-amount and electronic assignment of vouchers and transfer of funds would be encouraged to facilitate administration.

III. GUARANTEEING ACCESS TO COVERAGE FOR UNINSURABLE INDIVIDUALS THROUGH STATE HIGH-RISK POOLS

Conceptual approach: Authorize broad-based federal funding to encourage states to guarantee uninsurable individuals (those who would not qualify for private, medically underwritten individual policies) access to coverage through high-risk pools. While some states have chosen to implement other mechanisms to guarantee access to coverage, guaranteeing access to coverage through high-risk pools should be the preferred approach. Financing for high-risk pools at both the state and federal levels should be provided through broad-based funding.

Target population: Individuals who may be able to afford to pay a meaningful premium, or have a voucher or other subsidy available to pay a premium, but who do not qualify for private coverage due to health status.

Key elements of the proposal:

- Provide federal seed money to states without high-risk pools for start-up costs (program design and administration, initial reserves, outreach, etc.).
- Provide federal block grants for all states to defray administrative costs of high-risk pools.
- Provide 50-50 federal matching funds for the underwriting losses of pools (claims minus premiums). However, if a pool sets premiums below 150% of a standard private market rate, the match will be calculated as if the premiums were set at 150% of standard.
- To receive funds, state pools must have lifetime maximum benefits of no less than $1 million, and meet NAIC model high-risk pool standards.

- Federal reinsurance program for qualifying state high-risk pools will cover 75% of claims over $1 million for an individual pool enrollee (indexed to medical CPI).
- The Secretary of Health and Human Services (HHS) will establish pools in states if the state has not sponsored a pool (federal funds will be matched by withholding appropriate federal matching funds in such states).
- Any new state or federal funding for this program must be stable and broadly-based.
- States should replace guaranteed issue and community rating requirements in the individual health insurance market with guarantee access through high-risk pools

IV. ENCOURAGING GREATER COVERAGE FOR INDIVIDUALS AND SMALL BUSINESSES THROUGH ENHANCED TAX INCENTIVES

Conceptual approach: Provide a variety of additional tax subsidies, in conjunction with targeted consumer education, to encourage more individuals and employers to purchase private health insurance.

Target population: The self-employed, small businesses, and individuals without access to employer-sponsored health insurance coverage.

Key elements of the proposal (employer market):

- Small employer tax credit (could be phased-in beginning with smallest employers). To be eligible for the credit, a small employer must have an average payroll below the median for all small firms.
  - 40% credit for employers with fewer than 10 employees
  - 25% credit for employers with 10-25 employees
  - 15% credit for employers with 26-50 employees
- Allow employee contributions for health insurance to be excluded from taxable income (even if not made through a section 125 cafeteria plan)

Key elements of the proposal (individual market):

- Allow all individuals, not just the self-employed, to deduct the full cost of health insurance premiums.
- Undertake a variety of consumer education and outreach activities on the importance of having and maintaining health insurance.

V. ENCOURAGING INCREASED COVERAGE AND PROVIDING MORE OPTIONS FOR CONSUMERS BY EXTENDING AND ENHANCING ARCHER MEDICAL SAVINGS ACCOUNTS (MSAS)

Conceptual approach: Encourage more individuals and employers to purchase health insurance and save for future medical expenses by extending and enhancing Archer Medical Savings Accounts (MSAs). Increase the number of Americans who are given the option of establishing an MSA, and enhance the program to better meet the needs of the average American consumer.

Target population: Individuals and business of all sizes.

Key elements of the proposal (Medical Savings Accounts):

- Make MSAs more attractive by simplifying rules
  - Extend eligibility to large employers
  - Extend eligibility to all individuals—not just the self-employed
  - Eliminate sunset provision
  - Allow both employee and employer contributions to MSA account
  - Allow cafeteria plans to offer MSAs
  - Allow imbedded individual deductibles with family deductible cap
  - Increase the deduction allowed for MSA contributions to 100% of the deductible amount under the qualifying high deductible insurance policy
  - Increase the range of allowable deductibles and out-of-pocket limits (Lower limits are important to allow MSA holders' to limit their liability as they accumulate funds for medical expenses, and higher limits are important for policyholders who have accumulated, or expect to accumulate, significant funds in their MSAs).
  - Make it easier for PPOs and other network plans to offer MSA products
  - Preempt state benefit mandates to the extent that they would require a qualified high-deductible health plan to provide coverage below the level of the deductible. If this is not acceptable, then qualified high deductible health plans should be allowed to provide low-deductible or first-dollar coverage when necessary to comply with a state benefit mandate.

InsureUSA, through a combination of targeted subsidies for low-income individuals, federal matching funds for risk pools for individuals with serious medical conditions, and enhanced tax incentives to encourage the purchase of health insurance, addresses the need to ensure access to coverage to all Americans. But meaningful efforts must also be taken to reduce the cost of health care and make health insurance coverage more affordable. Costs must be addressed in three broad ways. First, regulatory burdens that increase the cost of coverage must be reduced. Second, individuals must take greater responsibility for ensuring that the health care they receive is paid for, and thus for ensuring that they have the health care coverage they need to fulfill that responsibility. Third, individuals must become more careful consumers of health care through increased control over and an increased financial interest in health care purchasing decisions.

Mr. BILIRAKIS. Thank you so much, sir.

Dr. Nelson.

STATEMENT OF JOHN C. NELSON

Mr. NELSON. Thank you, Mr. Chairman.

What an honor it is to be here on behalf of the American Medical Association physicians dedicated to the health of America to participate in this discussion on the crisis of the uninsured in America.

I also would like to thank you, Mr. Towns, for your leadership on the issue of the introduction of H.R. 2698.

My name is John C. Nelson MD. I am the President-Elect of the American Medical Association, and I am a practicing obstetrician and gynecologist in Salt Lake City. We appreciate the opportunity to be here.

That 41.2 million Americans lack insurance in 2001 is a problem, a major public health problem. As that number of uninsured climbs, the health care costs will continue to rise, which makes the problem of the uninsured—means it will get worse. The American Medical Association believes it is time to rethink health insurance, since a real human price is paid when individuals are uninsured.

First, the lack of health insurance has a direct-risk effect on the health of those uninsured; not having health insurance itself is a health risk. The uninsured receive less preventive care, they are diagnosed more often in the advanced stages of diseases, and they tend to seek care less often when they do have it. I think of a 22-year-old young woman who died of cervical cancer, a preventable disease, because she could not afford to have a pap smear.

Second, individuals who lack health insurance forego the needed medical care, so they are sicker when they get it. As a result, physicians who are already overburdened by increased liability premiums and decreased reimbursement are the ones forced to bear even higher costs to care about these Americans. In our State, we have a program called the Health Access Plan, or through the Utah Medical Association, we sign up to take care of those individuals within our specialty. I have the privilege of caring for some of these wonderful people. While not long ago, one was from Somalia, another from the Sudan, yet another from Bosnia people who don't have the ability to get the care that others would have. Perhaps most importantly, individuals in poor health are less likely to work at their fullest capacity, which is a drain on the engine of America's productivity. This means lost time, skills lost, people not being able to do what they should do because they are concerned.

To solve these problems, the AMA has long advocated that every American should have health insurance, and we propose reform that would dramatically increase the number of folks who are insured through a series of things which may start very well with H.R. 2698. We appreciate that positive step and think it is something that ought to be looked at. The AMA supports the use of health care certificates to reduce the number of the uninsured, our most vulnerable—those who don't have insurance are the most vulnerable—to assist individuals and their families to purchase health insurance.

Any certificate system must ensure that the lower-income Americans have the health insurance first. They get the vouchers or the certificates first. This means that the dollar value has got to be sufficient so that the care that they purchase is meaningful and affordable. H.R. 2698 would apply to individuals purchasing health insurance on the individual markets, but because some are uninsurable, perhaps we have to find a different way to take care of those folks, people with diabetes or some preexisting condition.

The AMA believes these individuals require targeted policies to subsidize their coverage and ensure that insurance markets allow affordable premiums for the general population. The concern is we have too many that are really sick and are really high-risk, that it costs so much to insure those that it increases the premium for everybody thereby making insurance not available even for those who otherwise could have afforded it. Therefore, we are very concerned that insurance pools should be encouraged by exempting them from selective State regulations regarding mandated benefits, premium taxes and small group rating laws. State and Federal patient protection laws have got to be safeguarded.

In addition, the AMA believes individuals should be able to buy into State employee purchasing pools or the FEHBP.

Further, appropriate market regulations should be pursued, greater uniformity across markets, modified community rating, guaranteed renewability, subsidization of high-risk individuals and the like through general tax revenues is a sounder approach than increasing premium taxes. We maintain that the ultimate solution to solving this problem of the uninsured is to encourage individual ownership and personal choice of affordable health insurance. This is America. One size does not fit all. We relish the idea of choice.

The cornerstone of our proposal is a plan of individual tax credits for the purchase of health insurance that is refundable, advancible and inverse income-related. We shared with the Congress, a publication further detailing this proposal. And if it is appropriate, Mr. Chair, I would submit this for the record.

Mr. BILIRAKIS. Without objection.

[The material is available at http//www.ama-assn.org/ama1/pub/upload/mm/363/expandinghealthinsur.pdf]

Mr. NELSON. We would ask the subcommittee to include in the record and having done that, simply want you to know the American Medical Association representing almost 300,000 physicians stands ready, willing, able, motivated and excited to participate in helping take care of this glaring public health problem.

Thank you very much for the opportunity to participate.

[The prepared statement of John C. Nelson follows:]

PREPARED STATEMENT OF JOHN C. NELSON ON BEHALF OF THE AMERICAN MEDICAL ASSOCIATION

Mr. Chairman and members of the Subcommittee, my name is John C. Nelson, MD, President-Elect of the American Medical Association (AMA). I am a practicing obstetrician in Salt Lake City. On behalf of the Association and its physician and student members, I thank you for the opportunity to share our views with the Subcommittee regarding the critical issue of reducing the number of individuals who lack health insurance. We especially thank this Subcommittee for holding this hearing, continuing to focus attention on the national health crisis of the uninsured, and working with the Administration and others on legislative solutions.

THE PROBLEM

According to the most recent Census Bureau figures released in September 2002, a staggering 41.2 million Americans lacked health insurance at some time in 2001. Data show that almost 1.5 million Americans became uninsured in 2001, due primarily to job loss. As these numbers remain high, health care costs continue to rise and the problem of the uninsured will likely worsen. The Center for Studying Health System Change reported that health care costs rose 9.6 percent in 2002. From 2001 to 2002, premiums for employer-sponsored coverage rose 12.7 percent, the largest increase since 1990.

Most of the uninsured are employed—78 percent are full time workers and 84 percent are in families headed by a worker. Only two-thirds of non-elderly Americans (those aged 64 and younger) are covered for medical expenses by an employer benefit plan. Thus, it is time to rethink health insurance since the problem of the uninsured involves several facets of our society, including health consequences to individuals, costs to the health care system, and lack of employee productivity.

Health Consequences Affecting Individuals

Lacking health insurance has a direct effect on the health of those uninsured. The uninsured receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates. For instance, uninsured women with breast cancer are twice as likely to die of cancer as women who have health insurance. Uninsured men are nearly twice as likely to be diagnosed at a later, and potentially more deadly, stage for colon cancer as men with health insurance. Uninsured individuals brought to the emergency room with severe injuries, are equally likely to be admitted to the Intensive Care Unit (ICU) when compared to privately insured individuals. Once admitted to the ICU, the uninsured, however, are less likely to undergo an operative procedure and are twice as likely not to survive their stay as those with health insurance benefits.

Costs to the Health Care System

Studies have also demonstrated that individuals who lack health insurance forego needed medical care and are sicker when they do seek care. They visit emergency rooms and are admitted to hospitals in disproportionate amounts, raising medical care costs which are then passed on to an already overburdened system. As a result, the already overburdened health care system is forced to bear even higher costs to care for these Americans. In 2001, total uncompensated care was an estimated $35 billion. The primary source of funding for uncompensated care is the government, which spent an estimated $30.5 billion for care on the uninsured, two-thirds of which are federal dollars.

Employee Productivity & Absenteeism Affected by Lack of Health Insurance

Individuals in poor health are less likely to work to their fullest capacity. Thus, health status is one of the many factors that determine the quantity (working time) and quality (productivity) of employees in the workplace. Uninsured individuals often put off receiving needed medical care. At the worksite, this translates into lost time, skills and productivity—through absenteeism or reduced efficiencies—that cost businesses money.

Poor health conditions affect one's ability to work and are costly to employers. Common conditions, such as migraine headaches, low back pain, diabetes, allergies, and depression, dominate health-related lost labor time. Although employees may go to work with these and similar conditions, costs of their performance can be substantially reduced. For instance, estimates indicate that depression costs U.S. employers $24 billion annually in lost productive work time.

SOLUTIONS

The AMA has long advocated for a health care system in which every American has health insurance. We propose health care finance reform which would dramatically increase the number of Americans with health insurance coverage while putting patients first in choosing an insurance package that best meets their needs. We suggest using health care vouchers or certificates (that are sufficient to cover a large cost of health insurance), fostering the development of new health insurance marts, implementing the appropriate insurance market regulation, offering refundable health care tax credits for individuals, promoting the individual selection and ownership of coverage, and developing defined contributions from employers.

Offer Health Insurance Certificates

Just last week, Chairman Bilirakis and Representative Towns introduced H.R. 2698, the "Health Insurance Certificate Act," which would seek to reduce the number of uninsured Americans by providing subsidies to low and low-middle income families for the purchase of health insurance coverage. In some cases, the certificates would reduce the financial burden of those who have already been paying for health insurance through either the individual market or their employer. Additionally, this legislation would adjust the value of the certificate based on an individual's or family's income.

The AMA supports the use of health care certificates to reduce the number of the uninsured and to assist individuals and families with their purchase of health insurance. This legislation takes an important step in accomplishing these critical goals. We believe that any health certificate system must ensure that lower income Americans would benefit from these certificates. Accordingly, the dollar value of certificates, such as those in this legislation, must be large enough to ensure that health insurance is affordable for most people. The certificates must at least be sufficient to cover a substantial portion of the premium costs for individuals in the low-income categories.

As previously mentioned, this legislation would apply to individuals purchasing health insurance on the individual market and to others who obtain health benefits through their employer-base insurance (group market). Due to their health status, some individuals are considered "uninsurable" when purchasing health insurance on the individual market. Such individuals require special, targeted policies in order to both subsidize their coverage and ensure that insurance markets allow affordable premiums for the general population. It is the AMA's preference to finance risk-related subsidies through general tax revenues rather than through premium surcharges, because premium surcharges have the unintended consequences of driving low-risk individuals out of the market, particularly low-income, low-risk individuals.

Foster the Development of New Health Insurance Markets

The AMA supports the development of new health insurance markets that offer a wide range of affordable coverage options. We believe that empowering people with tax credits, health insurance vouchers, and freedom of choice would dramatically transform today's health insurance markets. The new system would make health plans more responsive to patients, rein in premiums and health care costs, and stimulate the development of new forms of health insurance that better meet the wide range of needs of individuals and families. The influx of average-risk people into the individual health insurance market would prompt insurers to replace costly medical underwriting practices with simplified, automated ones. This would make coverage more affordable, particularly for those with pre-existing or chronic conditions.

The AMA also supports alternative means of pooling risk along the lines of existing prototypes, such as small group purchasing alliances and Internet-based health insurance vendors. To achieve this goal, the AMA supports federal legislation enabling the formation of "Health Insurance Marts" by affinity groups that could include coalitions of small employers, unions, trade associations, voluntary health insurance cooperatives, chambers of commerce and other community organizations.

Alternative insurance pools should be encouraged by exempting them from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws, while safeguarding state and federal patient protection laws. In addition, the AMA believes that individuals should be allowed to "buy in" to state employee purchasing pools or the Federal Employees Health Benefits Plan (FEHBP).Implement Appropriate Market Regulation [1]

[1] See Appendix A for AMA's principles for health insurance market regulation.

The AMA recognizes that in order for markets to function properly, it is important to establish fair ground rules. Neither free-market mechanisms, nor market regulations alone would fully meet the needs of those with chronic illness or conditions that are expensive to treat. The large number of existing state and federal health insurance market regulations has created problems. Regulations intended to protect high-risk individuals have actually driven up premiums and lead to a disproportionate number of young, healthy individuals to be without coverage. The combination of guaranteed issue, strict community rating, and extensive benefit mandates has had unintended effects on costs, coverage, and choice.

The AMA believes that greater uniformity across markets, modified community rating, guaranteed renewability, and subsidization of high-risk individuals through general tax revenues is a sounder approach than community rating or premium taxes. Such a regulatory environment would provide assistance to high-risk individuals without unduly driving up health insurance premiums for the remaining population; would provide individuals with incentives to be continuously insured; and would enable private market innovation, such as medical savings accounts (MSAs), consumer-driven health care plans, defined contribution health benefits, and new forms of coverage.

Protecting Vulnerable Populations

Vulnerable populations must also be protected. One way to protect some of those populations would be by intensifying outreach efforts to ensure that the five million children and adults who are currently eligible are enrolled in Medicaid and the State Children's Health Insurance Program (SCHIP).

Establish Tax Credits

The ultimate solution to solving the problem of the uninsured is to encourage individual ownership and selection of health insurance, as well as expand coverage to low-income workers who currently cannot afford coverage. The cornerstone of AMA's proposed plan is a system of individual tax credits for the purchase of health insurance that are refundable and income-related. The AMA would replace the current business tax deduction and employee exclusion for health insurance with a tax credit for the purchase of health insurance.

The current tax exclusion must first be converted to a tax credit for those who purchase health coverage, whether or not they receive health benefits from their employer. The tax credits should be inversely related to income; that is, larger credits should be available to families and individuals in the lower tax brackets. The size of the tax credits should also be large enough to ensure that health insurance is affordable for most people. The credits must at least be sufficient to cover a substantial portion of the premium costs for individuals in the low-income categories. In addition, the tax credits should be "refundable" so those who do not earn enough to owe taxes can still claim a credit.The current tax exclusion is inequitable because it provides a higher subsidy for those with higher incomes. Moreover, a large portion of the 41.2 million uninsured Americans are low-income wage earners who are not eligible for Medicaid. Under the AMA plan, the tax subsidy would be redirected toward those who need it most. Furthermore, compared to a tax credit that does not vary with income, a sliding scale tax credit reduces the federal spending necessary to expand coverage.

We have previously shared with the Congress an AMA publication further detailing our proposal to increase the number of Americans with health insurance entitled, "Expanding Health Insurance: The AMA Proposal for Reform." I have a copy here and ask the Subcommittee to include it in the record of this hearing. We hope that it proves helpful as you consider this subject.

Thank you again for the opportunity to testify and provide our suggestions for reducing the number of the uninsured. The AMA offers this Subcommittee and the Administration our assistance in advancing solutions to this critical issue.

APPENDIX A

The American Medical Association (AMA) supports the following principles for health insurance market regulation:

1. There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, and individual), geographic location, or type of health plan.
2. State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection.

3. Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges.
4. Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium.
5. Insured individuals should be protected by guaranteed renewability.
6. Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices.
7. Guaranteed issue regulations should be rescinded.
8. Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage.
9. The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically:
   (a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed.
   (b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options.
   (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.

Mr. BILIRAKIS. Thank you very much Dr. Nelson.

Mr. Shea, you are on.

STATEMENT OF GERALD M. SHEA

Mr. SHEA. My name is Gerry Shea. I am Assistant to the President of the AFL-CIO, where I manage government affairs, including health policy matters. And also, for the information of the committee, I represent the AFL-CIO in unions around the country in various health policy discussions such as the National Quality Forum, the Joint Commission on Accreditation, the Institute of Medicine and in past years on the MedPAC board. You have my written submission, and I wanted to supplement that with some additional comments here.

First, let me commend you for, in my view, seizing the opportunity that is provided by the Budget Resolution in beginning this debate. And our hope is it will be a full and robust debate about various ways to do that, and I commend you for the legislation you have submitted to begin that process.

I, likewise, am pleased to be joining such distinguished colleagues on this board, many of whom I know. And I would just make the point that, even though we may differ on policy, I think at the moment, we are more together on our values and our principles about what needs to be done to address this problem of uninsured than we are divided, even though we may have significant differences.

The worst rate of inflation in health care in American history has produced yet another crisis in the backbone of our coverage, that is employment-based coverage. While unions are proud of the fact that we're able to advance coverage for some low-wage workers in particular industries, for the most part, we are playing totally a defensive game in trying to hold on to coverage that was negotiated years ago. And I want to say that as much as we are rightfully—we are all rightfully concerned about the 47 million who are currently uninsured. I would suggest to the committee that you bear in mind, as I think you already do, that just behind those 47 mil-

lion, there are at least that number, or maybe many more, who are in serious risk of losing their existing coverage.

I will turn to the specifics of the bill that the chairman has introduced in a minute, but let me make a more general comment. Based on our experience, there is no solution to the coverage issue unless we can address the cost problem in American health care. We simply have an unsustainable situation in terms of the cost and the care that we get for that. And I would go one step further and say I don't believe, based on my experience, that there is any addressing successfully the cost issue without first addressing quality in the system.

Now, thankfully there are substantial steps being taken in that direction, in the private sector among businesses, in the health professions and within the government. I would particularly call to your attention the CMS activities and Secretary Thompson's outspoken leadership in terms of setting up information systems and providing information on reliable quality measures that are widely accepted as being important. And from the point of view of purchasers, my own view and experience in this, we want to start buying quality care and buying only the best quality care. We need more information and infrastructure to do that, but that is something that we hold as an important goal and one that, I believe, will lead us on the road to solving, long-term, the cost problems.

In terms of the specific legislation, let me say that first, I appreciate the fact that this legislation addresses the employment-based situation by providing subsidies for existing employment-based coverage.

I fear, however, and I should say first, and we are happy to accept the offer that has been made by my staff to talk about this at great length and to explore this and getting to potential areas of agreement. I fear, however, that in the present situation, this may not be the most efficient or effective use of the $50 billion over time that is available in terms of making any really substantial progress, in terms of adding to reducing the number of uninsured.

And I fear as well, as my written testimony indicates, that there may be unintended consequences here of actually undermining the employment-based area and that is probably the subject on which we could be most helpful. I would note that as with many members of the committee and others in town, we have spent a lot of time in the last 2 years, really dating back to the tragedy of September 11, 2001, looking at whether a tax vehicle could be configured to subsidize coverage. And I think in those discussions after many months of work, there were some very interesting ideas raised and some progress made. But I think if the phrase "the devil is in the details" ever applied to any area, it is in the health care field, as you know well, and therefore, you have to be very careful about how to structure this. And I think, as my written submission indicates, there are a number of issues that would need to be explored further.

Thank you, Mr. Chairman.

[The prepared statement of Gerald M. Shea follows:]

PREPARED STATEMENT OF GERALD M. SHEA, ASSISTANT TO THE PRESIDENT FOR GOVERNMENT AFFAIRS, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

Thank you for the opportunity to present the views of the AFL-CIO, a federation of 66 national and international unions representing 13 million active workers and 3.2 million retired members. We are pleased to offer testimony on H.R. 2698, the Health Insurance Certificate Act of 2003.

The AFL-CIO believes a full debate on how to best use the money allotted in the budget resolution can and should make a constructive addition to the current nationwide debate over the vexing problems of health care costs and coverage.

Employment based coverage is the backbone of our country's health care system. Nine out of ten insured in America receive their coverage through an employer. That represents 153 million active U.S. workers and their dependents and 19 million retirees, including over 5 million early retirees who don't yet qualify for Medicare. The AFL-CIO unions negotiate benefits for 40 million covered lives. Employers and unions that sponsor health plans use the purchasing power of pools of workers to negotiate for better prices and better quality, providing uniform coverage to all employees regardless of income or health status.

Until Congress enacts universal coverage that is financed equitably, any proposal considered in Congress must bolster—not undermine—this significant and successful segment of our health care system. Although a laudable initial attempt to use the $50 billion set aside in the budget for the uninsured, H.R. 2698 would seem to fail that critical test.

As drafted, H.R. 2698 could lead to several outcomes that would undermine employer-based coverage. First, employers may eliminate their coverage with the expectation that their workers will have the benefit of the federal subsidy. Second, employers may reduce the level of subsidy they provide for employees' coverage. Finally, employers may see their costs rise as younger, healthier workers opt out of the employer plan for a less comprehensive plan in the non-group market, leaving behind older, sicker workers in the employer plan

When employers eliminate coverage, workers either go without coverage or purchase inferior coverage that shifts substantially more cost onto the enrollee. Those who seek coverage in the non-group market are subject to vigorous medical underwriting, designed to separate the healthy from the sick. As a result, many cannot obtain coverage that is either affordable or adequate, and only those who are young and in good health can purchase a policy.[1]

That coverage, though, is far less comprehensive than group-based coverage, particularly employer-sponsored coverage. One study of coverage in the non-group market has found that half of people buying individual policies are covered for just 30 percent of their health care costs.[2] A similar study has found that individual policies that can be purchased for $1000 are often not available. Where they are available, coverage is woefully inadequate—sometimes requiring enrollees to meet a deductible of as much as $5000.[3] It's important to note that only the premium can be offset by the health certificate. The substantial cost sharing required by the policy must be borne entirely by the enrollee.

For those who cannot pass the vigorous medical underwriting, 30 states now have high-risk pools. However, premiums for these pools are typically very high and coverage often requires significant enrollee cost sharing or excludes coverage for preexisting conditions. One study done of 29 high-risk pools in 1999 found premiums averaged 168 percent of the standard market rate, but can go as high as 200 percent (in 8 states) and even 250 percent (in Florida). In dollar terms, this represents a significant cost—particularly for older individuals. In fact, in most states, the average premium—$3038—was high relative to ability to pay, and certainly significantly more than the value of the health certificate in H.R. 2698.[4]

Secondly, H.R. 2698 makes a distinction between employer plans with 50 percent or more of the premium paid by the employer and those plans with the employer contributing less than 50 percent. If an individual is enrolled in a plan in which the employer contributes 50 percent or more, they are only entitled to the group cov-

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[1] See for example, Karen Pollitz, Richard Sorian, and Kathy Thomas, "How Accessibly is Individual Health Insurance for Consumers in Less-Than-Perfect Health?" The Henry J. Kaiser Family Foundation, June 2001.

[2] Jonathan Gabel, "Individual Insurance: How much financial protection does it porovide?" Health Affairs, April 17, 2002.

[3] Families USA, "A 10-Foot Rope for a 40-Foot Hole: Tax Credits for the Uninsured, 2002 Update"

[4] L. Achman and D. Chollet, "Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools" Commonwealth Fund, August 2001

erage subsidy. However, if the employer contributes less than 50 percent, the individual is entitled to either the group coverage subsidy or the subsidy for non-group coverage. The difference between the two is that the group subsidy is valued at 40 percent of the non-group subsidy. This could provide an incentive for employers to reduce the level of their subsidy, since their employees would have two certificate options, one of which would be more valuable than is available to them in the employer's plan.

Another possible outcome of H.R. 2698 is that young and healthy workers may choose to opt out of the employer plan and use the federal subsidy to purchase a less comprehensive plan in the non-group market. This option—and the incentive of a greater federal subsidy if workers choose non-group coverage on their own—will segment the risk in the employer's pool, leaving the older and sicker workers in the employer's plan. The employer's costs will rise, driving up premiums and further threatening affordability for the employer and the workers who must contribute to the cost of their coverage. After several years of double-digit premium increases and more predicted for next year, embarking on such a policy is, in our view, shortsighted and unwise.

Finally, I would like to comment on Congress' most recent experience with federal subsidies for individuals to purchase health insurance, and one with which the AFL-CIO has been very much involved. The Trade Adjustment Assistance Act passed last year included a new health care tax credit for workers who lose their jobs as a result of U.S. trade policy and retirees whose pensions have been taken over by the Pension Benefit Guarantee Corporation. As you know, the tax credit subsidizes 65 percent of an individual's health care premiums and beginning in August, will be made available to workers at the time they purchase coverage. After much negotiation, the law requires the health coverage through the state-based options to include four consumer protections: guaranteed offer of coverage, no exclusions for coverage of pre-existing conditions, and premiums and benefits comparable to other insured individuals. However, we are very concerned that the law's restrictions on who qualifies for those consumer protections will prove to be a significant hurdle for the older workers and retirees this new tax credit purports to help.[5]

In addition, the House has already passed language that would severely undermine those consumer protections, slipping the provisions into an unrelated and otherwise popular bill, the Taxpayer Protection and IRS Responsibility Act (H.R. 1528). Unfortunately, this bill would further weaken another important protection. H.R. 2698 would increase and extend the funding for high-risk pools and at the same time, eliminate a number of important requirements: that high-risk pools can set their premiums at no more than 150 percent of the standard market rate and must offer two or more plans in order to qualify for the federal funds. Instead, H.R. 2698 only requires states to adhere to the NAIC model, which recommends states set premiums as high as 200 percent of the standard market rate. Eliminating this requirement is a blow not only to health care consumers but to the taxpayers who will be helping fund even more expensive coverage.

Another feature of H.R. 2698 that departs significantly from the TAA health care tax credit, and one which we oppose, is the capped value of the certificate. Setting the value of the subsidy at a fixed dollar rather than a percent of the premium discriminates against consumers based on their health status and where they live. The TAA program rightly recognizes that by providing a 65 percent federal subsidy, older workers and those with significant health care needs are more likely to find affordable coverage.

In conclusion, we welcome the debate on this important matter and appreciate the committee's work on developing a proposal for the $50 billion available for the uninsured. Without a doubt, both the rising number of uninsured and the importance the public has placed on this problem have made it a subject that demands the attention and commitment of all of us. However, we are concerned that the bill before the committee, H.R. 2698, fails to meet the AFL-CIO's primary test for health care policy: to strengthen and not undermine an already-fragile employment based system upon which most Americans depend for comprehensive, affordable health cov-

[5] Under the TAA law passed last year, these four consumer protections are only available to those individuals who have three months of prior coverage at the time "they seek to enroll" in state-based coverage. While the language is ambiguous and could be interpreted differently, the Administration has said individuals must have the prior creditable coverage at the time they are found eligible for the tax credit—many months after they were separated from employment and likely even longer for PBGC beneficiaries. It is highly unlikely that laid-off workers and retirees will have coverage at that point in time. Using this narrow interpretation of the test of prior coverage, none of the market protections would apply, yet without these protections, no retiree aged 55 to 65 and very few laid-off workers will get coverage.

erage. We would like to continue this dialogue and be very much involved in your discussions as they go forward.

Thank you.

Mr. BILIRAKIS. Thank you very much, Mr. Shea.

Ms. Spitznagel.

STATEMENT OF DEDE SPITZNAGEL

Ms. SPITZNAGEL. Mr. Chairman, members of the subcommittee, I am Dede Spitznagel, Executive Vice President of the Health Care Leadership Council, and I am here testifying today on behalf of the Coalition for Affordable Health Coverage. Thank you very much for this opportunity.

It is a privilege to appear in support of bipartisan legislation H.R. 2698 that will make private health insurance more affordable for lower-income workers and their families. The CHC is made up of 17 organizations sharing a common goal of making private health insurance more acceptable and affordable for the approximately 15 percent of Americans who are currently without coverage. Our members are health providers, employers, both large and small, insurers, pharmaceutical companies and consumers. My own organization, the, Health Care Leadership Council, is comprised of chief executives of the Nation's most respected health care companies and institutions. This coalition was formed 3 years ago in recognition of the critical nature of this issue.

In the United States today, there are millions of uninsured people who skip preventive care and end up with poor, and often more expensive, health outcomes. Emergency rooms become primary care clinics. We have a status quo that doesn't work well for patients, for health care providers, or for communities, or for taxpayers. All Americans will benefit when we provide the uninsured with increased access to private health coverage. In my testimony, I want to focus on how the chairman's and Mr. Towns's bill, the Health Insurance Certificate Act of 2003, moves us significantly toward that goal.

First, let us start by looking at the nature of the uninsured problem. A recent CBO study found that almost 60 million people go without health coverage for at least part of the year. But the number of people who are uninsured for a year or more is actually between 21 and 31 million, this group, people who tend to have low incomes who are not eligible for Medicaid, is exactly the population that H.R. 2698 wisely targets. There is a very important facet to this legislation that deserves highlighting. The bill provides a subsidy for those who do not have access to employer-sponsored health insurance. It also provides a lesser subsidy to those with access to employer-sponsored coverage. This is critical in reaching many of the uninsured. Many low-wage earners work for small employers who can provide only a minimal contribution toward coverage. Also, low-wage earners may not owe income taxes, and, therefore, may not benefit from the tax free status of the premium contributions made by their employers. For these working Americans, even a small subsidy can be just enough to help afford coverage.

In terms of affordability, one has to ask the question just how helpful will $1,000 for individuals or $2,750 for families be in pur-

chasing health insurance in the nongroup market. We believe these dollars will provide a very meaningful helping hand.

Let us look at the actual prices of health coverage today to determine the impact of these subsidies. According to the Nation's largest online brokerage, the average premium cost for individuals in 2002 was $2,011 per year, and it was about $4,188 for a family of three. This is the price for a comprehensive policy, the kind of health plan relied upon by most insured Americans. So using these figures, we see that if the chairman's bill becomes law, individuals could have an out-of-pocket expense of about $1,011 per year or about $85 per month, and families could have a premium expense of $1,938 per year or about $162 per month. The chairman's bill would pay, on average, 52 percent of the cost of health insurance. This is a tremendous boost for families that otherwise would have no assistance whatsoever. It is also important to note that H.R. 2698 provides $75 million in annual funding for high-risk pools, which would serve as a safety net for those who may have health conditions that prevent them from obtaining health insurance coverage. Through these pools, individuals with serious health conditions can gain access to affordable, high-quality insurance coverage.

The Coalition for Affordable Health Coverage believes that measures like H.R. 2698 are not only the right thing to do, they are also fiscally responsible. Last year our health care providers and facilities spent $35 billion to treat the uninsured. Not only does this affect the cost and availability of health care for all Americans, but our society and our economy are lessened when millions suffer from poor health and are less able to contribute in the workplace and in the classroom.

According to a recent report by the Institute of Medicine, the potential economic value to be gained if all Americans were to have health coverage is estimated at between $65 and $130 billion per year. So we commend the subcommittee for this hearing, and we applaud and support this legislation. You are addressing the population that needs your attention. Congress is moving toward the passage of a Medicare bill that will provide better health care to the elderly. Money has also been added to Medicaid to address the needs of those at the lowest level of poverty. This bill addresses the needs of the working poor, those who do not have the higher-wage jobs that bring with them more health coverage options. We are committed to supporting your efforts, and we thank you very much.

In addition, Mr. Chairman, I just wanted to mention, coincidentally, you have sitting here four members of the Robert Wood Johnson Initiative on covering the uninsured. And together, the four of us signed a letter on March 31, 2003 and sent it to all of the budget conferees, asking that the $50 billion in the Budget Resolution be maintained in the Budget Resolution. Now, we did get the $50 billion, and we just have to work together to create solutions.

Mr. BILIRAKIS. Would you like to put that in the record? Without objection that will be the case.

[The prepared statement of Dede Spitznagel follows:]

PREPARED STATEMENT OF DEDE SPITZNAGEL, CAHC BOARD MEMBER, EXECUTIVE VICE PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL

Mr. Chairman and Members of the Subcommittee: The Coalition for Affordable Health Coverage appreciates the opportunity to appear in support of H.R. 2698, The

Health Insurance Certificate Act of 2003, a bipartisan bill to make private health insurance more affordable for lower income workers and their families.

I serve as a Board member of the Coalition, a three-year-old group of 17 organizations who share a common goal of making private health insurance more accessible and affordable for workers and the 15% of Americans who currently have no coverage.

The members of CAHC include provider groups like the American Medical Association, the American Osteopathic Association, and the American College of Cardiologists. Our employer groups represent the spectrum, from large manufacturers to micro businesses. Members include the U. S. Chamber of Commerce, the National Association of Manufacturers and the National Association for the Self-Employed. The insurance sector participates in the Coalition with members like the National Association of Health Underwriters, Fortis Health, Aetna, and UnitedGroup Health. Pharmaceutical companies include Bayer, GlaxoSmithKline, and Wyeth. Consumers, such as farmers and self-employed individuals, are represented by the American Campaign for Consumer Choice and Lower Health Costs. My own organization, the Healthcare Leadership Council, represents the CEOs of more than 40 companies and organizations involved in all sectors of the healthcare industry.

Our diverse membership speaks with one voice when it comes to the uninsured: we support bills like H.R. 2698 that will help the uninsured afford private health coverage. Last year, the Coalition worked to see the creation of a health care tax credit on the Trade Adjustment and Assistance Act. This year, the Coalition worked with the Congressional budget committees and the leadership of both houses to include the $50 billion reserve fund for the uninsured in the 2004 Congressional Budget Resolution. Now, we appreciate the opportunity to share our views on a bill that will provide real help for the uninsured.

The Chairman's bill provides a certificate to low-income individuals and families that can be used to help pay for the cost of health insurance premiums. Who will benefit from this certificate and what do we know about them? These questions are important to answer, because understanding the people you are trying to assist is essential in crafting a solution that really works.

First, we know that those who are uninsured are clustered more heavily in the southeastern and southwestern states. They are disproportionately minority, and hardest hit is the Hispanic community where 35% are uninsured as compared with 12% of Caucasians.

Members of this subcommittee represent states that have the highest rates of uninsured in the entire country. If you look at the chart over to my (left/right), you may find your state listed if its uninsured rates are higher than the national average of 14.8%. For example, Representatives Barton, Hall, and Green will note that their state, Texas, has more uninsured residents than any other state: almost 1 out of 4 people in Texas are uninsured. Representatives Wilson, Waxman, Eshoo, Capps, and John are from states that rank second, third and fourth in the nation: New Mexico, California, and Louisiana. The two sponsors of the H.R. 2698 hail from states that are grappling with large uninsured populations. The Chairman's state, Florida, has the 7th highest number of uninsured, at 18%; and Representative Towns, also an original cosponsor, represents New York, which has the 16th highest rate of uninsured in the country.

I am certain you all know how these large populations of uninsured residents affect your states. Not only do the uninsured skip preventative care and end up with poorer and often more expensive health outcomes, their narrow choices cost communities more. Charitable physicians, community clinics, and public hospitals strive to be the safety net, and emergency rooms become primary care clinics. But none of this works very well for the patient, the community, the taxpayer, or the health care worker. We pay for this substandard system of care with higher taxes and premiums. All of us—and most especially the uninsured—would benefit from increased access to private health insurance. The Chairman's bill provides an effective way for this to occur.

A recent study by the Congressional Budget Office found that almost 60 million people go without health insurance for at least part of the year. Yet, when looked at closely, the study is actually very encouraging for policy makers who want to help the uninsured but are contending with tough fiscal realities. It turns out that many of the 60 million are without coverage for only a few months, often because they are between jobs. The number of people who are uninsured for a year or more is actually between 21 and 31 million. This latter group is the one for whom the Chairman's legislation could make a significant difference, because those who are uninsured for longer periods of time tend to have low incomes, but not low enough to qualify for Medicaid.

This is just the group that H.R. 2698 wisely targets. If you look at the "pie chart" I have displayed, it shows the income levels of those who are uninsured. As you can see, about 40% of the uninsured earn less than 150% of the poverty level. The income limits in the Chairman's bill are at about 143% of the poverty level. This means that the bill could benefit about 60% of those who are uninsured.

The legislation provides a subsidy for those *without* access to employer sponsored health insurance, and it would also provide a partial subsidy to those *with* access to employer sponsored health insurance coverage. Many low-wage earners work for small employers who can provide only a minimal contribution towards coverage. Also, low wage earners may not owe income taxes and therefore may not benefit from the tax-free status of the premium contributions made by their employers. For these individuals and families, it is often a choice between health insurance and other essential living expenses. Even a small subsidy could be just enough to help them afford coverage.

Providing $400 to an individual or $1100 to a family to help them pay their portion of the employer premium will equalize the value of the certificate for those with and those without a tax-exempt employer offer. And it rewards people who have chosen to do the right thing. In addition, an employee premium subsidy helps small employers maintain coverage for the group as a whole, as most small group health plans require a minimum percentage of employees to participate in the plan, or the coverage won't be issued.

Questions have been raised as to how much "bang for our buck' can be gained from a subsidy that may result in employers dropping or reducing health care coverage for their workers. CAHC has serious reservations about the methodologies used in assuming displacement or "crowd out" of employer coverage. Health insurance is a very important benefit sought by workers in lieu of wages. And employers care deeply about the health and well being of their employees, particularly in small businesses where the business owner works alongside employees and knows their families and personal situations. Offering health coverage helps employers compete for and retain employees, and it keeps their workforces healthy, at work, and back at work sooner following an illness.

In addition, under H.R. 2698, employers have a large disincentive to reduce or discontinue their contributions toward health coverage since the subsidy is targeted only to the low-income portion of their workforce.

Further, a look at previous experiments where employers were offered government wage or childcare subsidies demonstrates that employers do not necessarily reduce their overall contribution in the presence of a subsidy. For example, a Florida study looking at the effects of welfare reform on the earnings of the working poor found that increases in funding for child care subsidies led to an overall *increase* in the earnings of the working poor.

The question will naturally arise as to just how helpful $1000 (individual) or $2750 (family) would be in purchasing health insurance in the non-group market. We believe that it can be very helpful. It is not the intent of the Chairman that this bill pay for 100% of anyone's premium cost and create a new federal entitlement program. People are naturally better stewards when they have something invested. So, how much of a personal investment are we talking about?

Figures from the largest national online brokerage show that the average premium cost for individuals in 2002 was $2,011 per year and $4,188 for families of three. Between 80% and 90% of these policies would be considered "comprehensive" in coverage, so we are talking about the kind of policies that most insured Americans might enjoy.

These figures indicate that—with the assistance of the Chairman's bill—individuals will have an out-of-pocket expense of $1,011 per year, or about $85 per month. Families would have a premium expense of $1,938 per year, or about $162 per month. The Chairman's bill pays—on average—about 52% of the cost of health insurance. This is a tremendous boost for families that, otherwise, would have no assistance. In addition, these out-of-pocket expenses could be slightly less since over 60% of the uninsured are under the age of 35, presumably a less expensive group to cover, resulting in lower premiums.

Wisely, the Health Insurance Certificate Act provides $75 million in funding each year from 2004 through 2009 for state high-risk pools. As you know, high-risk insurance pools exist in 30 states and serve as a "safety net" for those who may have health conditions that prevent them from obtaining health insurance coverage. Although the number of individuals with serious health conditions is small, the cost of their health care can be tremendously high. High-risk pools provide a source of affordable high-quality health insurance coverage for those without access to employer sponsored plans. In states where high-risk pools are the safety net for individuals with health conditions, both healthy and unhealthy individuals enjoy lower

health insurance rates than in states that require mandatory guaranteed issue coverage for everyone.

CBO examined survey data describing the reasons people give for being uninsured. More than 60 percent said that "cost" and "lack of access to employment-based coverage" were their reason(s) for being uninsured. Yet, only about 4 percent of responders cited poor health as a reason for going without health insurance. Although this group is small, we can presume that they are likely to be high users of public health care and so it is important to ensure that they have a viable alternative. By supporting the creation and providing assistance with the ongoing funding of high-risk pools, H.R. 2698 recognizes the need for a viable "safety net" for this sicker population.

There may be an additional concern among some about spending $50 billion this year on the uninsured, given the country's tight fiscal situation. To those, I would like to refer to the very substantial cost this country already incurs for uncompensated care. Last year, the nation's health care providers and facilities spent $35 billion to treat the uninsured. In its recent report, *Hidden Costs, Value Lost, Uninsurance in America,* the Institute of Medicine notes that when people lack health insurance, the cost to society is substantial. The report further notes:

> The economic vitality of the country is diminished by productivity lost as a result of the poorer health and premature death or disability of uninsured workers. The potential economic value to be gained in better health outcomes from continuous coverage for all Americans is estimated to be between $65 billion and $130 billion each year.

Finally, I would like to commend this Committee for their concern about the working poor. This legislation is timely, and it has the potential to addresses a significant number of the uninsured population.

This year, Congress will likely create new and expanded health benefits for the elderly in the Medicare Reform bill. For the very poor, we have Medicaid, to which Congress added money this year. But one group is conspicuously missing: the so-called "working poor" who do not have the higher wage jobs that allow more coverage options. This group needs affordable access to health insurance. Both Republicans and Democrats have made helping the uninsured a theme in Presidential campaigns. The Health Insurance Certificate Act puts policy to those words. I hope the Committee will move this forward and the Coalition, representing so many and such diverse organizations, is committed to supporting your efforts.

For further information on the Coalition for Affordable Health Insurance, please contact: Laura Clay Trueman, Executive Director, 1615 L Street, NW, Suite 650, Telephone (202) 626-8573, Fax (202) 626-8593, Email: ltrueman@jeffersongr.com

Uninsured By State Ranking & Subcommittee Members

State	Rank	% of Uninsured	Subcommittee Member
Texas	1	24%	Rep. Barton
			Rep. Hall
			Rep. Green
New Mexico	2	21%	Rep. Wilson
California	3	20%	Rep. Waxman
			Rep. Eshoo
			Rep. Capps
Louisiana	4	19%	Rep. John
Arizona	6	18%	Rep. Shadegg
Florida	7	18%	Rep. Bilirakis
Georgia	8	17%	Rep. Norwood
			Rep. Deal
Mississippi	9	16%	Rep. Pickering
Wyoming	13	16%	Rep. Cubin
Colorado	15	16%	Rep. DeGette
New York	16	16%	Rep. Towns
			Rep. Engel

All of other states represented on the Subcommittee fall under the national average on uninsured, which is 14.8%.

Mr. BILIRAKIS. Mr. Greenstein.

STATEMENT OF ROBERT GREENSTEIN

Mr. GREENSTEIN. Thank you very much, Mr. Chairman.

Few priorities should rank higher than reducing the ranks of the uninsured. And I join my fellow panelists in congratulating you for taking this matter on and attempting to fashion a new approach toward addressing this issue.

Having said that, I do have some significant concerns about H.R. 2698. Principally around the issue that I believe the reduction in the ranks of the uninsured, what it would achieve would be modest and not what one would want to get for $50 billion. I also have a concern that it may encourage some States to scale back Medicaid and SCHIP coverage to shift financial responsibility to the Federal Government, which would pick up 100 percent of the cost of the health certificates.

Let me turn to the issue of how effective it would be in reducing the ranks of the uninsured. One of the Nation's leading experts on these issues is Professor Jonathan Gruber at MIT. In recent days, he has conducted an informal analysis of a proposal very similar to H.R. 2698. His projection is that close to 90 percent of the expected health certificate participants would be people who are already insured and that only 1.3 million of the uninsured would gain coverage. By the way, in doing the assumption, he essentially treated this as a mandatory program. If the Appropriations Committee didn't appropriate the full amount you intend, it would be even less than the 1.3. His findings are consistent with prior research, and the reason is that he finds that the vast majority of participants would either be people who are already in employer-based coverage paying an employees share of the premium who would get a subsidy for the premium they are already paying or already purchasing coverage in the individual market and would get a subsidy for that. Of particular concern is that older and sicker workers who are not insured would have difficulty making—getting insurance with the health certificate because for those people going into the individual market, even a $2,750 subsidy falls well below what they will be charged, if they are able to secure coverage at all. And it is very often the case for older and sicker people that, in fact, they can't purchase comprehensive coverage in the individual market. Yet, they are the people that need the comprehensive coverage the most.

I am also concerned for low- and moderate-income people that the subsidies involved, the $2,750, would be insufficient to enable them to cover—to purchase family coverage, comprehensive coverage in the individual market. According to the GAO, the mid-range premiums for family insurance in the individual market was about $7,300 in 1998. The prior panel quoted a much lower figure, but I think the problem with the figure that was quoted is it reflects the costs for policies currently being purchased in the individual market. The individual market, at present, is primarily used by people who are healthier than average, and this doesn't reflect the prices that are quoted to less healthy people who then end up not buying coverage in the individual market because they conclude they can't afford it.

Of particular concern, if I understand the bill correctly, is that the subsidy amounts, the health certificate subsidy amounts are fixed, that they don't rise from year to year. But, with health care premiums rising at often double-digits rates, then as the years go

by the subsidies would cover a smaller and smaller percentage of the cost of the premium.

With regard to low-income employees, the biggest issue here are those for whom the employer does not offer coverage as distinguished from those where the employer does offer and they can't afford it. This could help for those where the employer offers and they can't afford it, might make some modest gains in coverage there; not a big effect in those cases there where the employer is not offering to begin with.

A note of concern on the Medicaid and SCHIP side, and a final issue, I will note, which I just had difficulty in reading the bill, is understanding the administrative structure. There really isn't an administrative structure laid out for who determines the eligibility, whether you meet the asset and the income limits. Is it the States? Is the Federal Government? If it is the States, do they get the administrative costs covered for determining the subsidies? The administrative structure is not really laid out in the bill.

A final concern is on the one hand your bill is careful to target the subsidies to a group with low income and low assets, and because of that targeting, the risk of employers dropping coverage in response to the health certificates is small. I am concerned, however, that if an approach like this got enacted, and future Congresses significantly increased the income and asset limit, this approach would then pose a significantly larger risk of employer dropping.

So where does this all lead me? I think where it leads me, Mr. Chairman, is to concluding that there is an alternative type of approach that I think would be more efficient and effective with the $50 billion in reducing the ranks of the uninsured. And that would really be building on the SCHIP program that was enacted on a bipartisan basis in 1997. I am specifically thinking of the bipartisan Family Care proposal here, the notion of increasing Federal allotments to States in the SCHIP program, one could provide the bulk of the $50 billion in increased allotments, SCHIP allotments to States, and then allowing the States to cover the parents in particular, or first the parents of children whom SCHIP already covers.

As you may know, the Medicaid income limit for parents in the median State today, is only about 70 percent of the poverty line. We did see that when SCHIP was set up, States significantly expanded coverage for low-income children. We have had major progress in reducing uninsurance among low- and moderate-income children. And by broadening SCHIP and covering parents, we could make substantially further progress.

I would also note that, in my view, the very first claim perhaps, within the $50 billion, this would just be a small piece of it, is making sure that we don't go backwards on SCHIP. As you know, Federal SCHIP funding went down a billion a year starting in 2002. So far that hasn't been a problem, because there were unspent SCHIP funds from the earlier years, and you and your colleagues very fortunately have passed and hopefully before you go home, will reach agreement on a temporary fix by having the expired SCHIP funds continue. But that only takes us through about the end of 2004, and our projections, using the CMS SCHIP expendi-

ture model, the HHS expenditure model, is that without some additional funds in SCHIP, that between now and 2007, the number of low-income children insured through SCHIP will go down 370,000, as the unspent funds from the earlier years run out, and the effect of the billion dollar a year funding cut works it way through the system.

Surely, we should not let the progress made on a bipartisan basis covering children in SCHIP go backwards. Now, let me just finally say that we do have evidence that the approach of covering parents, through a SCHIP-type approach is very efficient. Secretary Thompson, when he was the Governor in Wisconsin, he pioneered something called Badger Care. He expanded coverage, he and the legislature expanded coverage to parents up to 185 percent of the poverty line. Studies indicate that fewer than 10 percent of those who came on had previously been insured.

Other studies find similar results for other parent expansions through the public program route. Again, this is a big contrast with the estimates Professor Gruber has come up with for the Health Certificate bill.

Medicaid and SCHIP, the family care-type approach, also has the benefit that there would be no problem for the older and sicker people, they wouldn't have to go into the individual by themselves.

Mr. BILIRAKIS. Please summarize.

Mr. GREENSTEIN. They get the basic comprehensive coverage.

So just to conclude, if we look at the three key goals of reducing the ranks of the uninsured, avoiding adverse side effects in employer or public coverage, and making sure the sicker people can get adequate coverage, I think that the family care-type of approach, building on the SCHIP block grant would be a more effective use of the $50 billion, trying to achieve the same goal that you are trying to achieve in your bill.

Thank you.

[The prepared statement of Robert Greenstein follows:]

PREPARED STATEMENT OF ROBERT GREENSTEIN, EXECUTIVE DIRECTOR, CENTER ON BUDGET AND POLICY PRIORITIES

I appreciate the invitation to testify today. I am Robert Greenstein, Executive Director of the Center on Budget and Policy Priorities, a non-profit policy institute that conducts research and analysis on fiscal policy and on programs and policies affecting low- and moderate-income families. The Center does not hold (and has never received) a grant or contract from any federal agency.

My testimony today focuses on evaluating approaches for expanding coverage to the 41 million Americans currently without health insurance, particularly the Health Insurance Certificate Act of 2003 (H.R. 2698), which is the subject of this afternoon's hearing. The problem of the uninsured is likely to worsen, at least in the short term. During the current economic downturn, some families are at risk of losing their jobs and their health insurance. In addition, facing the worse budget crises since World War II, states are struggling to maintain their Medicaid and State Children's Health Insurance Program (SCHIP) coverage.

Initiatives to cover more of the uninsured are needed. While the goal of the Health Insurance Certificate Act of 2003 is very laudable, I believe the legislation has some serious shortcomings. The proposal is unlikely to help reduce the ranks of the uninsured by an amount commensurate with the expenditure of $50 billion. The proposal also could encourage some states to scale back existing coverage under Medicaid and SCHIP to shift financial responsibility from the states to the federal government.

Furthermore, if eligibility for the health certificates is substantially expanded over time and the program is more adequately funded, the health certificate proposal could weaken the traditional employer-based health insurance system through

which the vast majority of Americans obtain their health insurance and could thereby cause some workers' current access to affordable and comprehensive health insurance to be placed at risk.

Employer-based coverage and public programs such as Medicaid and SCHIP are the twin pillars of the health insurance system in the United States. In 2001, the latest year for which data are available, 162 million non-elderly individuals obtained their health insurance through an employer.[1] (By comparison, only 16.4 million obtained private health insurance coverage through the individual market.) In 2003, about 50 million non-elderly individuals and families receive coverage through Medicaid or SCHIP. Initiatives to expand coverage should build on these pillars of health insurance in the United States, rather than risk weakening them.

To address the problem of the uninsured without weakening existing coverage, a better alternative would be a carefully designed expansion of public programs such as Medicaid and SCHIP. Under the "FamilyCare" proposal, additional federal funding would be provided to states, at their option, to expand Medicaid and SCHIP to more parents in working families. Research shows that expanding coverage to parents so parents and children can be covered by the same public program produces the additional benefits of an increase in enrollment among eligible-but-uninsured children in these programs and an increase in utilization of necessary health care services by children. Such a proposal would strengthen public programs that have a proven ability to provide affordable, comprehensive health insurance to millions of low- and moderate-income families. It also would be a much more efficient use of $50 billion—substantially more of the uninsured would gain insurance, and far less of the money would "leak" to subsidizing people who already are insured. Another sound alternative could involve tax incentives for more small employers to offer health insurance to their workers.

EVALUATING APPROACHES TO EXPANDING COVERAGE TO THE UNINSURED

In this testimony, I use several principles in evaluating proposals to reduce the ranks of the uninsured.

A proposal should do no harm to the existing health insurance system through which the vast majority of families obtain their health coverage.

Any proposal to expand coverage to the uninsured should not weaken the ability of the existing employer-based health insurance system and public programs like Medicaid and SCHIP to continue to offer affordable, comprehensive coverage to millions of Americans. If a proposal has the inadvertent effect of encouraging employers or states to scale back health insurance coverage, any gains in new coverage could be offset in substantial part or in whole by resulting losses in existing coverage (or by a lessening of the affordability or quality of existing coverage).

An example of a policy that could have an adverse effect is the health tax legislation to establish Health Savings Security Accounts (HSSAs). This legislation was passed by the House three weeks ago and included as part of the Medicare prescription drug bill and is intended, at least in part, to help cover the uninsured.[2] HSSAs would likely have the effect, however, of encouraging employers to move away from traditional health insurance plans—which include low deductibles and modest copayments and provide comprehensive benefit coverage—to less comprehensive, high-deductible insurance, where employees bear a greater proportion of health care costs. Low-income, older and sicker workers could be disproportionately affected and have reduced access to necessary health care services.

A proposal should be well-targeted to maximize the number of uninsured individuals and families gaining health care coverage.

The overwhelming majority of the assistance provided under any coverage proposal should go to families currently without health insurance. For example, a proposal could be targeted to low-income families that are least able to afford health insurance. Such families are also most likely to work in small firms, which offer health coverage to their workforces at a substantially lower rate than do larger firms. A proposal would not meet this test if most participants either already had insurance through employer-based coverage (and would, under the health certifi-

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[1] Paul Fronstin, *Sources of Coverage and Characteristics of the Uninsured: Analysis of the March 2002 Current Population Survey,* Issue Brief no. 252, Employee Benefit Research Institute, December 2002.

[2] For an analysis of these accounts, see Edwin Park, Joel Friedman and Andrew Lee, *Health Savings Security Accounts: A Costly Tax Cut that Could Weaken Employer-Based Health Insurance,* Center on Budget and Policy Priorities, revised July 8, 2003.

cation bill, start to receive a subsidy for employee premiums they already are paying) or merely shifted their existing insurance arrangements (for example, by moving from employer-based coverage to the individual market).

A proposal should provide accessible, affordable, and comprehensive health coverage to uninsured families.

Any proposal to expand health insurance coverage should ensure that uninsured families eligible for the new assistance actually have access to health insurance. Families with older or sicker members should not be excluded from obtaining coverage because of their poorer health status, as is often the case in the individual market. To assure access, a proposal should make health insurance affordable. Modest assistance that still requires a low-income family to pay a prohibitive proportion of its gross income is unlikely to be very successful in encouraging the purchase of health insurance coverage.

Research has found that uninsured individuals and families are less likely to have regular access to health care services and that this can lead to poorer health outcomes.[3] Research has also shown that if individuals with insurance have a less comprehensive policy, with higher deductibles, substantial copayments and a narrow array of covered benefits, their access to needed health care services may be limited (albeit less so than if they have no insurance at all).[4]

DESCRIPTION OF H.R. 2698, THE "HEALTH INSURANCE CERTIFICATE ACT OF 2003

I turn now to the "Health Insurance Certificate Act of 2003" (H.R. 2698), the focus of today's hearing. The bill would establish a new program to provide subsidies to individuals and families for the purchase of health insurance. Under the bill, individuals under the age of 65 who are not eligible for public health insurance coverage and meet certain income and assets requirements could participate.

Eligible individuals and families would receive a "health certificate" from the Secretary of Health and Human Services to help purchase health insurance. To use the health certificate, participants would provide the certificate to a health insurance issuer. The issuer would subsequently receive a direct payment from the HHS Secretary equal to the value of the subsidy for which the individual or family is eligible. The certificates could be applied to health insurance in the individual market (including coverage obtained through a high-risk pool), COBRA coverage provided through a former employer, or the employee's share of the premium for health insurance offered through his or her job.

For the purchase of health insurance in the individual market, the annual subsidy would be up to $1,000 for individuals and up to $2,750 for two-parent families with children, with the full subsidy being available only to individuals with incomes of less than $13,000 per year and families with incomes below $25,000. The subsidy would phase down as income rose above these levels and phase out entirely when income exceeded $18,000 for individuals and $34,000 for a two-parent family of four.

The health certificate also could be used to pay for an employee's share of the premium cost of employer-based coverage, so long as the employer subsidizes at least 50 percent of the cost of health insurance. This provision is intended to assist uninsured employees who are offered insurance through their job but cannot currently afford their share of the premium. The annual subsidy for employer-based coverage would be limited to $400 for individuals and $1,100 for families of four. The subsidy for employer-based coverage would phase down by income at a somewhat faster rate than the individual market subsidy, phasing out entirely when income exceeded $16,000 for individuals and $33,000 for families.

In no case could the value of the annual subsidy exceed 70 percent of the premium cost of either individual market or employer-based coverage. The subsidy amounts would not be indexed for inflation. In addition, the asset limits in determining eligibility would be set at $12,500 for individuals and $20,000 for families. These asset limits, as well, would not be indexed for inflation.

The health certificates program would not be a mandatory program. It would be funded solely on a discretionary basis under the annual appropriations process. The bill authorizes total appropriations of up to $28.5 billion between fiscal years 2004 and 2008 (no year-by-year authorization levels are provided) and up to about $50 billion over ten years. The number of certificates available each year to eligible individuals and families would be subject to the availability of appropriated funds. The

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[3] See, for example, Institute of Medicine, *Health Insurance is a Family Affair,* September 2002; Jack Hadley, *Sicker and Poorer: the Consequences of Being Uninsured,* Kaiser Family Foundation, May 2002.

[4] Elisabeth Simantov, Cathy Schoen and Stephanie Bruegman, *Market Failure? Individual Insurance Markets for Older Americans,* Health Affairs July/August 2001.

bill would allow up to $75 million of the appropriated funds each year to be used to extend and increase modestly the existing funding for state high-risk pools.

EVALUATION OF THE HEALTH CERTIFICATE ACT OF 2003

The health certificates are highly unlikely to be a cost-effective and well-targeted approach to reduce the ranks of the uninsured, since the large majority of those who would use the subsidy already have insurance.

The goal of the health certificates bill—to target assistance to low-income families—is laudable. These are the families most likely to be uninsured, least likely to have access to health insurance through their employment, and least able to purchase health insurance on their own.

There is serious question, however, about the bill's effectiveness and efficiency in achieving this goal. Professor Jonathan Gruber of M.I.T., an expert in analyzing the effects of coverage proposals on the uninsured, has conducted an informal analysis of a proposal similar to the health certificates bill.[5] He projects that about nearly 90 percent of expected health certificate participants would previously have had health insurance. This is because the vast majority of participants are expected to be people who either are already insured through employer-based coverage—and could start getting a subsidy for the employee premiums they are already paying—or are already purchasing individual-market coverage on their own.

This analysis is consistent with prior research conducted both by Professor Gruber and by the Kaiser Family Foundation, which found that under similar coverage proposals using refundable tax credits rather than direct subsidies—such as the health tax credit the Administration has proposed—more than two-thirds of participants would be people who already were insured.[6] As a result, only a relatively modest share of the benefits of the health certificate subsidy likely would go to reducing the ranks of the uninsured. A larger share of the subsidy costs would go to provide people who already are insured with financial assistance.

Older and sicker individuals not eligible for employer-based coverage would likely be unable to secure adequate health insurance in the individual market without paying exorbitant amounts.

The individual market is generally unregulated. Under the health certificate proposal, a family containing older or sick members could find itself excluded from coverage in the individual market or charged premiums that are unaffordable, even with a $2,750 subsidy. The individual market generally permits individual medical "underwriting"—that is, insurers can vary premiums based on age and medical history and can deny coverage entirely. The health certificate bill does not include any reforms of the individual market.

According to a study by the Commonwealth Fund, only 16 states require that insurers offer a plan to most applicants in the individual market, and this does not necessarily mean an affordable plan.[7] Another Commonwealth Fund study found that among adults aged 19-64 who sought coverage in the individual market and who were in poorer health or suffered from chronic conditions, 62 percent found it very difficult or impossible to find a plan they could afford that provided the coverage they needed.[8]

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[5] In his analysis, Professor Gruber assumes the subsidy is provided as a refundable tax credit at a cost of $4.2 billion in the first year. Factoring in health care inflation, the approach Professor Gruber modeled could be more costly than would be allowed under the discretionary funding limit of $50 billion over 10 years set in the health certificate bill. The informal analysis Professor Gruber conducted found that 1.38 million previously uninsured individuals would gain coverage out of an estimated total participation of 12 million people. Thus, only 11.5 percent of participants would previously have been uninsured. A small number of individuals previously enrolled in employer-based coverage are projected to become uninsured, reducing the net gain in coverage to 1.28 million people.

[6] Jonathan Gruber, Written Testimony before the Subcommittee on Health, House Ways and Means Committee, February 13, 2002; Judith Feder, Cori Uccello, and Ellen O'Brien, *The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance,* Kaiser Family Foundation, October 1999. The Administration's own estimates of its tax credit proposal from last year, issued by the Treasury Department, indicate that nearly two-thirds of tax-credit recipients would have already had health insurance. Testimony of Mark McClellan before the Senate Health, Education, Labor and Pensions Committee, March 12, 2002. For analysis of the Administration's tax credit proposal, see Edwin Park, *Administration's Proposed Tax Credit for the Purchase of Health Insurance Could Weaken Employer-Based Health Insurance,* Center on Budget and Policy Priorities, revised April 22, 2003.

[7] Lori Achman and Deborah Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools,* The Commonwealth Fund, August 2001.

[8] Lisa Duchon and Cathy Schoen, *Experiences of Working-Age Adults in the Individual Market,* The Commonwealth Fund, December 2001.

A Kaiser Family Foundation study examined the response that hypothetical families and individuals applying for coverage in the individual health insurance market would meet; the hypothetical applicants were structured to test the medical underwriting process through 60 applications in eight geographic markets. The study found that older and sicker people, even those with relatively mild conditions, are often unable to obtain comprehensive coverage in the individual market.[9]

Alternatively, such a family could be offered a plan that is affordable but does not provide coverage for a variety of significant medical conditions. Many plans in the individual market do not offer comprehensive coverage. They may require high deductibles, impose significant cost-sharing, and provide limited benefits. Many individual market plans require deductibles of $1,000 or more—on average, deductibles are set at $1,550 in the individual market. Individual market plans also often do not cover the broad range of benefits available in comprehensive employer-based coverage. Plans available in the individual market may not cover preventive benefits or mental health services, for example, and may place stringent limitations on prescription drug coverage. A recent study by the Commonwealth Fund found that individual market plans rarely include maternity benefits.[10] On average, individual market plans cover 63 percent of medical costs, as compared to 75 percent under group insurance plans. Half of people buying individual policies are covered for only 30 percent of their health care bills.[11]

People enrolled in individual insurance may delay treatment because of potential out-of-pocket costs or because benefits are not covered. One study found that older individuals with individual coverage are twice as likely as those with employer-based coverage to fail to see a doctor when a medical problem has developed or to skip medical tests or follow-up treatment.[12] Another study concluded that so-called "bare-bone" health plans, comparable to some of those found in the individual market, could leave low-wage individuals and families with catastrophic health care costs well in excess of their annual income.[13]

The health certificates would be of inadequate size to make health insurance in the individual market affordable for many low- and moderate-income families.

Comprehensive health insurance can be expensive. According to the General Accounting Office, the mid-range premium for family insurance in the individual market exceeded $7,300 in 1998. Even without factoring in the increases in health insurance premium costs since 1998, a family of four with income of $25,000 that receives a $2,750 subsidy would have to expend 18 percent or more of its gross income to purchase insurance at this price.

A Commonwealth Fund study examined premiums for individual health insurance policies that provide coverage comparable to what employer-based insurance typically provides. The study looked at premium costs in 17 cities for policies for a single healthy adult aged 55. It found the median annual premium for these policies to be approximately $6,100.[14] Thus, with a subsidy of $1,000, a 55 year-old with income of $15,000 would have to pay $5,100 "more than one-third of his or her gross income—to obtain such insurance. A less healthy person generally would have to pay still more, if he or she were not excluded entirely from the individual market. Moreover, in some high-cost geographic areas, premiums could consume even larger percentages of family income. For example, premiums for a healthy 55 year-old were more than $9,500 in the Los Angeles-Long Beach, California area.[15] The subsidy would reduce that cost only to $8,500.

Studies indicate that premium costs of these magnitudes are well beyond what most low-income families can afford. One study determined that premiums set at

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[9] Karen Pollitz, Richard Sorian and Kathy Thomas, *How Accessible is Individual Health Insurance for Consumers in Less-than-Perfect Health?,* Kaiser Family Foundation, June 2001. See also Karen Pollitz and Larry Levitt, *Explaining the Findings of a Study About Medical Underwriting in the Individual Market,* Kaiser Family Foundation, May 2002.

[10] Sara Collins, Stephanie Berkson and Deirdre Downey, *Health Insurance Tax Credits: Will They Work for Women,* The Commonwealth Fund, December 2002.

[11] Jon Gabel, Kelly Dhont, Heidi Whitmore and Jeremy Pickreign, *Individual Insurance: How Much Financial Protection Does It Provide,* Health Affairs (Web Exclusive), April 17, 2002.

[12] Simantov, Schoen and Bruegman.

[13] Sherry Glied, Cathi Callahan, James Mays and Jennifer Edwards, *Bare-Bones Health Plans: Are They Worth the Money,* The Commonwealth Fund, May 2002.

[14] Jon Gabel, Kelly Dhont and Jeremy Pickreign, *Are Tax Credits Alone the Solution to Affordable Health Insurance,* The Commonwealth Fund, May 2002.

[15] Gabel, Dhont and Pickreign. *See also* Collins, Berkson and Downey, which found that individual market premiums for women varied significantly across geographic areas.

or above five percent of income discouraged most low-income families from enrolling in health insurance.[16]

Finally, the value of the health certificate subsidy is likely to erode significantly over time. Under the bill, the subsidy amounts available under the health certificate program are not adjusted annually. Insurance premiums could rise at double-digit rates from year to year while the subsidy remained frozen.[17]

The health certificates are likely to encourage only modest increases in participation in employer-based coverage by low-income workers.

Allowing the health certificates to be used by employees to pay for their contribution to the cost of health insurance is likely to increase participation in employer-based health insurance only modestly. This is because most uninsured low-income workers are uninsured not because they cannot afford employee premiums but because their employer does not offer them coverage.[18] Only 40 percent of low-wage workers earning less than $7 per hour were offered health insurance through their employer, as compared to 96 percent of higher-wage workers earning at least $15 per hour.[19] In another analysis, the Commonwealth Fund looked at low-wage workers employed by small businesses with fewer than 25 workers. In 2001, only 36 percent of small-business employees who earned less than $10 per hour were offered health insurance coverage, as compared to 67 percent of small business employees earning more than $15 per hour. The Commonwealth Fund study found that as a result, 37 percent of workers earning less than $10 per hour in small businesses were uninsured.[20]

Moreover, for those uninsured workers with access to employer-based coverage, the health certificate subsidies may encourage firms—particularly small firms with large numbers of low-wage workers—to lower their premium contributions in response.[21] As a result, the bill could end up substituting substantial new public dollars for existing employer contributions. While the health certificate bill requires that employers must subsidize at least 50 percent of health insurance coverage for an employee to qualify for assistance, employers could reduce the health insurance premium contribution they are currently providing so long as they do not reduce it below 50 percent. As a result, such firms may shift a greater proportion of the premium costs of health insurance to their employees, knowing their workers can use the health certificate to help offset those costs. Such an outcome is most likely to occur among very small employers with substantial numbers of low-income workers who already pay for a smaller proportion of the costs of health insurance, rather than among larger firms and firms with substantial numbers of higher-income workers.

Establishment of the health certificates could encourage some states to scale back Medicaid and SCHIP coverage for families with children.

Facing severe budget deficits, some states have recently scaled back eligibility for working parents and children under Medicaid and SCHIP. (The state fiscal relief package included in the recently enacted tax bill is likely to avert or reduce the magnitude of some pending reductions.)

The health certificate subsidy is targeted to the same low-income individuals and families who currently are served or could be served by those public programs. For families of four, income eligibility for the full certificate subsidy would be capped at $25,000 per year. This equals 136 percent of the poverty line. Forty states now provide Medicaid or SCHIP coverage to children in families with incomes up to 200 percent of the poverty line. While many states have been less generous with eligibility for working parents in such families—income eligibility for parents in the median state was only 69 percent of the poverty line in 2001—some 20 states including

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[16] Leighton Ku and Teresa Coughlin, *Use of Sliding Scale Premiums in Subsidized Insurance Programs,* Urban Institute, March 1, 1997.

[17] The average cost of employer-based health insurance increased 12.7 percent between 2001 and 2002. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey,* September 2002.

[18] Leonard Burman, Cori E. Uccello, Laura L. Wheaton and Deborah Kobes, *Tax Incentives for Health Insurance,* Urban-Brookings Tax Policy Center, May 2003.

[19] Diane Rowland, Written Testimony before the Subcommittee on Health, House Committee on Energy and Commerce, February 28, 2002.

[20] Sara R. Collins, Cathy Schoen, Diane Colasanto and Deirdre A. Downey, *On the Edge: Low-Wage Workers and Their Health Insurance Coverage: Findings from the Commonwealth Fund 2001 Health Insurance Survey,* the Commonwealth Fund, April 2003.

[21] Burman, Uccello, Wheaton and Kobes.

the District of Columbia covered working parents up to 100 percent of the poverty line or higher.[22]

Because the health certificate subsidy would be targeted in part at the same low-income adults and children served by these public programs, it could give states facing budget pressures an inducement to reduce Medicaid and SCHIP coverage. States could decide that some beneficiaries should instead use the health certificates to purchase health insurance in the individual market. After all, unlike public programs such as Medicaid and SCHIP that require states to contribute a portion of the costs, the health certificate would be fully funded by the federal government. As a result, beneficiaries who now have access to affordable and comprehensive public coverage through Medicaid or SCHIP could be placed into the individual market and become uninsured or face much higher out-of-pocket costs and significantly reduced benefits.

Access to the health certificates would be substantially limited by significant administrative hurdles.

The health certificate bill does not indicate how it would resolve several administrative obstacles in implementing the health certificate program. For example, the bill limits eligibility by imposing income and asset limits. While the bill states that the Secretary of Health and Human Services is responsible for developing a methodology for calculating income and assets, it does not delineate how eligible individuals and families would apply and who would make the eligibility determinations. States already conduct eligibility determinations for programs like Medicaid and SCHIP, but there is no requirement in the bill that states process health certificate applications or that states receive additional federal funding to do so. If the federal government is to determine eligibility for the health certificates, it would have to establish a new bureaucracy to administer it.

Moreover, the bill states that a health insurance issuer may receive payment directly from the Secretary of Health and Human Services equal to the value of the subsidy when an individual or family presents a health certificate to the issuer. This is intended to ensure timely advance payment of the subsidy so that individuals do not have to pay the premiums first themselves—which is likely to be impractical considering the families' low incomes—and wait to receive the subsidy from the federal government. There are no provisions, however, that describe the structure and procedures through which these advance payments would be made. For example, one unresolved issue is how the federal government will identify and reimburse individual insurers and employers providing coverage to individuals and families eligible for the health certificate.

The health certificate program would not have mandatory funding and would be subject to the vagaries of the annual appropriations process.

Under the health certificate bill, no mandatory funding is provided for the program. The bill only includes an authorization for funding to be provided through the annual appropriations process, with a limit of just under $28.5 billion for the next five years as a whole and a limit of just under $50 billion over the 10-year budget window. The number of certificates provided would be subject to the amount of discretionary funding actually made available each year.

Since no funds or only a small amount of funds could be appropriated for the program, there is no guarantee that a significant number of individuals and families would receive a health certificate subsidy to purchase health insurance. Alternatively, adequate funding could be provided in the program's first few years, but funding could subsequently be reduced as appropriators struggled to fit within stringent appropriation caps.

On the other hand, if the program receives substantial funding increases over time, use of the health certificate program is likely to be significantly more widespread. That would result in more families receiving the certificates. It would, however, also increase the risks that the certificates would pose to the employer-based health insurance system and public programs.

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[22] Several states including Connecticut, Missouri and New Jersey have recently reduced eligibility for parents due to their budget deficits. Other states such as Arizona, Illinois and New York have expanded eligibility since 2001.

If expanded substantially over time to families at higher income levels, the availability of the health certificates could lead some employers to cease providing health insurance coverage to their workers and could induce many new employers not to offer coverage.

Analysts from M.I.T., the Kaiser Family Foundation, and the Urban Institute have found that enactment of a subsidy for the purchase of health insurance (done through the tax code as a refundable credit) would encourage some firms not to offer health insurance coverage to their employees because the firms would know their workers could now get a subsidy to purchase coverage in the individual market.[23] This is not likely to be the case under the health certificate program: the restrictive income and asset limits would mitigate that risk.[24] In examining tax credits, the Urban-Brookings Tax Policy Center found that if eligibility for such credits is limited to families with low-incomes, fewer employers will drop coverage since the credits would be unavailable to many of their workers. The availability of partial subsidies for employer-based coverage also should somewhat reduce the likelihood that firms would drop coverage.[25]

As a result, the magnitude of the risks the health certificate bill could pose to the employer-based health insurance system would be limited. If over time, however, the health certificate income and asset limits were lifted to increase eligibility and funding were increased substantially, the program could end up weakening employer-based health insurance coverage and encouraging a substantial number of employers to drop their health insurance coverage (or not to offer coverage in the first place).

Substituting the purchase of health insurance in the individual market for group coverage through an employer would seriously disadvantage older and less healthy workers. As discussed above, in most states, insurers can vary premiums for health insurance policies offered in the individual market on the basis of age and medical history and can refuse to cover people entirely. Many older and less healthy workers would generally have to pay far more than the amount that the subsidy would provide to secure coverage in the individual market or would not be able to obtain coverage at all because of their health status.

If expanded substantially over time, the health certificates could institute an "adverse selection" cycle.

Some young, healthy low-income workers whose employers do offer coverage but require their employees to pay a substantial share of the premium would be able to opt out of employer-based coverage and instead use their health certificate subsidies to purchase insurance in the individual market.

The movement of substantial numbers of workers from employer-based coverage to the individual market is not likely, however, because of the restrictive income and asset eligibility requirements. Relatively few workers in these income ranges have access to employer-based coverage. In addition, the availability of a partial subsidy for employer-based coverage could offset some of the incentives to leave employer-based coverage for those low-income workers participating in such coverage. (However, because the health certificate program provides a greater subsidy for the purchase of health insurance in the individual market then for employer-based coverage, it may still encourage some young, healthy employees to leave employer-based coverage for the individual market.[26])

The health certificate proposal, however, could be expanded in subsequent years through Congressional action to remove these income and asset limitations. Such a move could make it attractive for more young and healthy employees to opt out of employer-based coverage and shift to the individual market. If these young and healthy workers opt out of employer coverage, however, the pool of workers remaining in employer plans would become older and sicker, on average. That would drive

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[23] Burman, Uccello, Wheaton and Kobes; Jonathan Gruber, *Tax Subsidies for Health Insurance: Evaluating the Cost and Benefits,* National Bureau of Economic Research, February 2000; Judith Feder, Cori Uccello, and Ellen O'Brien, *The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance,* Kaiser Family Foundation, October 1999; Leonard E. Burman and Amelia Gruber, *First Do No Harm: Designing Tax Incentives for Health Insurance,* National Tax Journal, May 2001; and Linda Blumberg, *Health Insurance Tax Credits: Potential for Expanding Coverage,* Urban Institute, August 2001. The Administration also acknowledges that some tax credits could have this adverse effect on employer-based coverage. Council of Economic Advisers, *Health Insurance Tax Credits,* February 13, 2002.

[24] Professor Gruber expects little or no employer dropping under the health certificate bill because of the restrictive income and asset limits.

[25] Burman, Uccello, Wheaton and Kobes.

[26] Burman, Uccello, Wheaton and Kobes.

up the average premium costs for employer-based insurance and further raise the amounts that the employees remaining in these plans must pay for insurance.

This phenomenon—known as "adverse selection"—could then induce yet additional younger, healthier workers to abandon employer-based coverage and use their subsidies in the individual market instead, since the departure of the first wave of younger, healthier employees would have caused premiums for employer-based coverage to rise. In this way, a vicious cycle could be set in motion. The increase in premiums for employer-based coverage that ultimately could occur could induce some employers either to cease offering health insurance or to increase substantially the amounts their employees must pay for insurance. The end result could be that a substantial number of older and less healthy individuals could eventually lose their employer-based coverage and become uninsured or underinsured or have to pay very large amounts for decent coverage.

Intensifying the risk that many firms might not offer coverage is the recent return of a high rate of inflation in health care costs, which are now rising at double-digit rates. As a result, fewer firms, especially small businesses, are offering health insurance coverage to their employees. Institution of an expanded health certificate subsidy with substantially higher income and asset limits could provide a further incentive for some employers, especially small businesses seeking to cut costs, to drop or not to institute coverage for their workforce.

MORE EFFECTIVE APPROACHES TO COVERAGE OF THE UNINSURED

FamilyCare

A more effective and efficient alternative that would avoid the principal pitfalls of the health certificate approach is to expand public programs like Medicaid and the State Children's Health Insurance Program (SCHIP). Public programs are a proven approach to reduce the ranks of the uninsured. For example, according to the Centers for Disease Control and Prevention, the percentage of low-income children who are uninsured fell by about one-third, from 23 percent in 1997 (when SCHIP was established) to 16 percent by 2002, in large part because of public programs.[27]

The effective safety net role of Medicaid and SCHIP has also been highlighted during the current economic downturn as families have lost their jobs and their health insurance. According to other CDC data released last year, the number of children who were uninsured would have been two million higher and the number of uninsured adults would have been one million higher in the first quarter of 2002 (as compared to 2001) but for increased Medicaid and SCHIP enrollment picking up the slack.[28]

One public program expansion proposal that would be particularly effective in addressing the problem of the uninsured is the bipartisan "FamilyCare" legislation, introduced in the last Congress, that would provide $50 billion in new SCHIP funds to assist states, at their option, in expanding Medicaid and SCHIP coverage to the low-income parents of children eligible for those programs.

In 2001, some 34.5 percent of parents—about 6.6 million—in families with incomes below 200 percent of the poverty line ($36,800 for a family of four) were uninsured. This is partly the result of limited coverage within the Medicaid program; in 2001, the Medicaid income eligibility level for parents in the median state was only 69 percent of the federal poverty line (about $12,700 for a family of four). Just as SCHIP facilitated coverage expansions for low-income children, additional federal SCHIP funds could be provided for states to expand Medicaid and SCHIP coverage to low-income working parents.

A number of states such as Arizona, Illinois, New Jersey, Rhode Island, and Wisconsin have expanded SCHIP (or are in process of implementing such an expansion) to provide comprehensive coverage to parents, as well as other adults. However, the long-term ability of states to continue to expand coverage is threatened by a lack of adequate federal SCHIP funding. The Balanced Budget Act of 1997 instituted a 26 percent reduction in federal SCHIP funding for the fiscal years 2002, 2003 and 2004—a reduction of over $1 billion each year. In addition, the SCHIP redistribution system suffers from timing and targeting problems. Some states have federal funds they will never use, while other states face the prospect of having to cut their pro-

[27] Centers for Disease Control and Prevention, National Center for Health Statistics, "Early Release of Selected Estimates Based on Data from the 2002 National Health Interview Survey," June 2003.

[28] Leighton Ku, *The Number of Americans without Health Insurance Rose in 2001 and Appears to be Continuing to Rise in 2002,* Center on Budget and Policy Priorities, revised October 8, 2002.

grams sharply in the future years because their federal SCHIP allotments will be insufficient. As a result, even with the likely passage in coming days of bipartisan legislation to extend the life of $2.6 billion in expired or expiring SCHIP funds, a number of states are projected to have insufficient funding to sustain their existing programs over the next few years.

Greater SCHIP funding provided under the FamilyCare approach would not only address funding shortfalls for existing SCHIP coverage of children but would provide additional resources for expansions to their parents. If history is any guide, when states are given new flexibility to expand coverage and sufficient additional funding, they will take up the option and expand coverage, in many cases substantially. Examples include the significant increase in children's coverage after SCHIP was created and a number of Medicaid expansions for parents following enactment of welfare reform in 1996, which gave states more options in this area.

The FamilyCare proposal benefits from a number of advantages over other approaches to cover the uninsured:

- It would not encourage many individuals to drop employer-based coverage, nor would it significantly induce employers no longer to offer health insurance to their workers, especially as compared to the likely effects of other approaches. Research has found that a relatively modest percentage of the additional individuals covered through public expansions previously had employer-based coverage.[29] For example, an examination of Minnesota's Medicaid expansion to adults and children found that only seven percent of enrollees gave up private insurance (both employer-based and individual market) to join the program, of which fewer than half previously participated in employer-based coverage. In Wisconsin, which expanded coverage to parents up to 185 percent of the poverty line through its BadgerCare program, only 6 percent of the 25,000 families screened had access to employer-based coverage prior to enrolling in the SCHIP program. Other studies estimating the effects of public program expansion proposals project that only 30 percent of participants would have previously had insurance.[30] By comparison, as discussed above, Professor Jonathan Gruber estimates that nearly 90 percent of participants in the health certificate bill would previously have had health insurance.
- The coverage provided under Medicaid and SCHIP is accessible and affordable to the low-income populations served. Unlike the individual health insurance market, public programs are open to any eligible individual irrespective of age or medical history. In addition, both the Medicaid and SCHIP programs have limits on premiums, deductibles and cost-sharing to ensure that participating families and individuals can afford out-of-pocket costs. Research shows that premiums and cost-sharing above minimal levels deter participation or use of necessary care among low-income families.[31] Medicaid generally requires no premiums and nominal copayments and exempts vulnerable populations such as children and pregnant women from any cost-sharing. SCHIP families are protected from cost-sharing that exceeds 5 percent of family income.
- Medicaid and SCHIP coverage also provides comprehensive benefits that meet the needs of older and sicker families and individuals. Both programs establish federal benefit standards that are intended to provide comprehensive health insurance coverage. Under Medicaid, states must provide certain minimum benefits such as hospital, physician coverage and nursing home care, as well as preventive, acute-care and long-term care benefits that meet the special needs of children, people with disabilities and people with chronic illnesses. Under SCHIP, state programs must generally provide a benefits package that is equivalent to a basic benchmarks, such as the Blue Cross-Blue Shield Standard Option under the Federal Employees Benefits Health Plan (FEBHP).

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[29] Lisa Dubay, *Expansions in Public Health Insurance and Crowd-Out: What the Evidence Says,* Kaiser Family Foundation, October 1999; Kathleen Call et al., *Who Is Still Uninsured in Minnesota? Lessons from State Reform Efforts,* Journal of the American Medical Association, October 8, 1997, p.1191-95; Leighton Ku, Marilyn Ellwood et al., *The Evolution of Medicaid Managed Care Systems and Eligibility Expansions,* Health Care Financing Review, Winter 2000; Jeremy Alberga, *Wisconsin's BadgerCare Program Offers Innovative Approach to Family Coverage,* Robert Wood Johnson Foundation, January 2001; Amy Lutzky and Ian Hill, *Has the Jury Reached a Verdict? States' Early Experiences with Crowd-Out Under SCHIP,* Urban Institute, June 2001; and Richard Kronick and Todd Gilmer, *Insuring Low-Income Adults: Does Public Coverage Crowd-Out Private?,* Health Affairs, January/February 2002.

[30] Feder, Uccello and O'Brien; Judith Feder, Written Testimony before the Subcommittee on Health, House Committee on Energy and Commerce, February 28, 2002

[31] Judith Feder, Larry Levitt, Ellen O'Brien and Diane Rowland, *Covering the Low-Income Uninsured: The Case for Expanding Public Programs,* Health Affairs, January/February 2001.

- Expanded coverage of low-income parents under Medicaid and SCHIP would also have the added benefit of increasing coverage of children who currently are eligible for, but not enrolled in, the Medicaid or SCHIP programs. Many low-income children who are eligible for these programs remain unenrolled and uninsured.[32] Research has found that extending health insurance to low-income parents under the same public program so that the entire family can be covered under a single joint policy boosts enrollment of children and use of necessary services by children. In states that have expanded publicly funded coverage to include working parents, enrollment rates among children are significantly higher.[33]
- Finally, Medicaid and SCHIP already have a working administrative structure in place; there would be no need to establish a new bureaucracy to implement the FamilyCare expansion. In fact, since SCHIP has been established, states have simplified and streamlined enrollment procedures for eligible families. States know how to determine income eligibility for Medicaid and SCHIP coverage and how to facilitate families' enrollment in health insurance plans. States have existing contracts with providers and managed care plans; expansion participants would receive their comprehensive benefits through existing coverage arrangements that the state has already established. In many cases, families would already be familiar with the Medicaid or SCHIP managed care plans, doctors and hospitals because their children already participate in those programs.

Small Employer Tax Credits

Another approach to the problem of the uninsured that could be considered, possibly in conjunction with FamilyCare, would be to provide additional subsidies to small businesses to offer health insurance coverage to their workers. As discussed above, small employers especially those with large numbers of low-income workers, are less likely to provide health insurance to their workforces.

The federal government could provide a tax credit to small businesses (say for firms with fewer than 50 workers) that offer health insurance benefits, with the value of the credit equaling a percentage of the employer's premium costs. The credit would be available both to employers currently providing such coverage and to businesses not currently offering health benefits. According to a Kaiser Family Foundation survey of small businesses, 89 percent of small business executives supported offering tax credits to employers to help them purchase health insurance for their employees.[34]

To maintain a relatively modest cost and target the credit to the most vulnerable small businesses that are least able to offer coverage, the credit could be designed to provide the greatest subsidy to the smallest firms *and* the firms with substantial numbers of low-wage workers. Professor Jonathan Gruber of M.I.T. has suggested the design of such a credit. While the credit would be available to all firms with fewer than 50 workers, the subsidy would be largest for the smallest firms (say firms with fewer than 10 workers or some higher level), with the value of the credit slowly phasing out by firm size. In addition, the credit would be targeted at firms with a high percentage of low-wage workers. The value of the credit would be largest for firms whose average wage is less than some annual earnings benchmark or hourly wage level, with the credit slowly phasing out above that level. In other words, the credit would phase out along two dimensions: firm size and wage level.

This design has the benefit of targeting the greatest subsidy to the small businesses that most need it while still providing some financial assistance to all small businesses offering health insurance that have fewer than 50 workers. Most importantly, the credit would not disrupt—and would build on—the current employer-based health insurance system. It would assist the relatively few small employers with large numbers of low-income workers that currently offer traditional coverage

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[32] See, for example, Lisa Dubay, Ian Hill and Genevieve Kenney, *Five Things Everyone Should Know about SCHIP,* Urban Institute, October 1, 2002.

[33] Institute of Medicine, *Health Insurance is a Family Affair,* September 2002; Leighton Ku and Matthew Broaddus, *The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms,* Center on Budget and Policy Priorities, September 2000; Jeanne Lambrew, *Health Insurance: A Family Affair,* The Commonwealth Fund, May 2001; Lisa Dubay and Genevieve Kenney, *Covering Parents Through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children;* Kaiser Family Foundation, October 2001; Elizabeth Gifford, Robert Weech-Maldonado and Pamela Farley Short, *Encouraging Preventive Health Services for Young Children: The Effect of Expanding Coverage to Parents,* Pennsylvania State University, presentation at the Academy for Health Services Research and Health Policy Conference, Atlanta, June 12, 2001.

[34] Kaiser Family Foundation, *National Survey of Small Businesses,* April 2002.

so they can continue to afford such coverage, while also encouraging other firms to begin offering coverage. It would not produce the adverse selection risks likely to result from tax credits and subsidies for health insurance in the individual market, which could lead to significant increases in premium costs for traditional group health insurance coverage and thus could place older and sicker workers at risk of becoming underinsured or uninsured.

According to a Kaiser Family Foundation survey, 61 percent of small business executives believe employees would be better off in employer-based coverage than on their own in the individual market, and 74 percent thought it would be harder for employees to meet their health insurance needs if they got sick if the employees were in the individual market rather than in employer-based coverage. A tax credit to small businesses would meet these preferences and concerns.

CONCLUSION

In evaluating proposals to covering more of the uninsured, three principles should govern. A proposal should do no harm to the health insurance system through which the vast majority of families obtain their health insurance. A proposal should be well-targeted to maximize the number of uninsured individuals and families gaining health coverage. And a proposal should provide accessible, affordable and comprehensive health insurance coverage to uninsured families.

Carefully designed expansions of Medicaid and SCHIP, as well as certain tax incentives for more small employers to offer health insurance coverage, would satisfy these principles.

Mr. BILIRAKIS. Thank you, sir.

Well, a few months ago, must have been maybe the middle of last year, I visited virtually every Chamber of Commerce. I made this statement publicly at least once in my District. And where it used to be you would attend the Chambers and, you know, find out what their problems are and things of that nature, it was always things like infrastructure, et cetera, well, this time it was health insurance. And I mean resoundingly, across the board. Every one of them. So there is no question about the problem.

There is a problem there for the uninsured. There is a problem there for the employers. There is a problem.

I have very unrehearsed questions. We have laws that require you to be able to—if you have a driver's license, you have got to have automobile insurance. And I don't know of any cases, there may be some, but I don't know of any cases where the premiums are subsidized by government or any form of government. But I guess somehow people needing a car or needing transportation manage to raise the money to pay for those policies, and they are pretty darn high.

I guess the question might be, is that something we should consider doing? Mandating health insurance, that everybody have health insurance, every family have health insurance? When I use the word mandating, you know there is more than one way you can mandate something or encourage it, if you will. Any of you? Any thoughts? Dr. Young?

Mr. YOUNG. Well, I think there are several questions that it raises. All of the answers to which have impacts that need to be considered. Mandating who? The individual. If you mandate the individual, how are you going to enforce it? And what would the financial impact be on very low-income that were mandated to a premium that they simply couldn't afford? But the same is true if you were to do it for business now, particularly small businesses. Now, large businesses virtually all offer insurance. But, if you have a mom and pop business with two or three employees, they are struggling to do the right thing, and they are offering insurance, but

they are having a hard time. And you mandate on them, what is that going to do to the business, and what is that then going to do to our economy? So I think it is a question that can be raised and discussed, but it—the answer to it has implications that have to be probed and understood.

They could be significantly negative implications. I think the better approach is the one that you are taking, and that is, providing financial assistance, hopefully, over time additional financial assistance, letting people buy into it. Their employer pays them, they pay some, the subsidy pays some, it is combined, shared funding.

I think they that will get you to where you want to go and maintain the health of our economy.

Mr. BILIRAKIS. Very briefly, any further comments? I only have 5 minutes, so it is going to have to be brief.

Mr. NELSON. The American Medical Association thinks there is a better way to do it. Incentives would work better than a mandate. It is a carrot or a stick. In this case, a carrot or a club. We prefer the carrot.

Mr. SHEA. I warned the chairman that there would be a few policy differences here. I don't think we are going to solve this problem unless we have everybody included. And however we determine is the best basis for the system, my own current thinking is, we have an employment-based system, we need to build on that.

I think we are going to have to have everybody included one way or the other. Now, as Dr. Young points out, this is going to require some significant subsidies for small employers.

Mr. BILIRAKIS. Everybody included, meaning the full 41 million or whatever the figure is uninsured?

Mr. SHEA. And all of the employers, if we are going to have an employment-based system they need to be participating.

Ms. SPITZNAGEL. I agree with all of those comments. We have a system now that has a lot of problems. The No. 1 problem is affordability. A lot of people want to purchase insurance. It is not that they have the affordability and they can't and they just don't want to, they would like to purchase it. There are more devils in the details that Dr. Young had mentioned, in addition to what Dr. Young mentioned, including the issue of having to define, for instance, what they would be mandated to purchase.

And that could become very controversial, and it could lock a lot of people out of the coverage system and make the idea of an individual mandate very prohibitively expensive if we settled on a requirement that this mandate be applied toward a very rich Cadillac insurance plan.

Mr. GREENSTEIN. I was going to say, the key is accessibility and affordability. If we really found the way, which we are a long way away from today, of making health care accessible and affordable to everyone in the country, one could then consider an individual mandate.

But, one would have to solve the problem of making it accessible and affordable to older and sicker people as well as the younger and healthier people. That is really the tough problem. If we get over that hurdle, we might not need an individual mandate or we might be able to do one, but we are a long ways from there now.

Mr. BILIRAKIS. How many—of all of the people that are in the category of uninsured, do you know, we just keep referring to uninsured, insured, uninsured. And uninsured is significant. But I guess my biggest concern is, are people getting adequate proper health care in this wealthiest country in the history of the world?

How many of these people are getting what we might call adequate or close to adequate health care? Do we know?

Mr. YOUNG. On average across the pool of the uninsured, the spending on their behalf is about 50 percent of what the spending would be for a fully insured individual. A large share of that is spending that occurs in the hospital and occurs at a time of an emergency, or occurs at a catastrophic kind of an event.

What they are not getting are the preventative services, the routine services, a child with asthma is not getting the drugs that prevents the asthma attack that leads to the hospital stay. So they are consuming a substantial amount of resources, but they are the wrong kinds of resources.

You need to do the others that prevent those kinds of hospital stays as well.

Mr. BILIRAKIS. Any other further comments?

Mr. NELSON. It was referred to that about $35 billion is spent each year to care for those who are uninsured when they finally do get to the system. How much could one prevent with that $35 billion? A pap smear, the clinical preventative services, prenatal care, and pneumococcal vaccines and diabetic medic screening and so on. The cost would be astronomically saved. We are spending at the wrong end. It is not efficient.

Mr. BILIRAKIS. Are you saying that we should focus on whatever the few dollars, heck, to say $50 billion is few, it is kind of crazy, but that is the way it is up here. Are you saying that we should be focusing those dollars maybe toward something like that?

Mr. NELSON. Yes, sir. I think they are the most cost-effective things that we can do. To be honest with you, the most cost-effective thing we do in health care, prenatal care. Moms who come in and keep their visits have larger babies, healthier babies, fewer cesarian sections, and cost less.

There is a lot of evidence of this, Mr. Chairman. This is a good place where this bill might be able to focus.

Mr. BILIRAKIS. So we shouldn't be concerned then necessarily about insurance, if you will, but——

Mr. NELSON. They still have to have access. So the coverage by the insurance would be a way to make us to do that.

Mr. SHEA. Mr. Chairman, I would just add that the work of this committee and others in Congress on patient safety legislation, which hopefully we will see realized this year is an element in this whole troubling picture, because, we know from the Institute of Medicine studies that we waste huge amounts of money on unnecessary care in this country.

As I was saying before, we just need better quality standards. The simple truth of the matter is, we pay the same whether it is great care, mediocre care, or dangerous care. We have to stop doing that. If we stop doing that, there is going to be a lot of money available for doing other things.

Mr. BILIRAKIS. Well, my time is up. But I would sure like to spend more time on that subject.

The Chair now recognizes the gentlelady from California for 8 minutes because she waived her opening statement.

Ms. CAPPS. Thank you, Mr. Chairman.

I think you set off a series of questions in a very interesting way. And I think it was George W. Bush's predecessor who had the same request, that everybody have health insurance. But, the question of affordability and accessibility is a big question.

Mr. Greenstein, I want to ask you some questions to allow you to give a fuller answer. But you didn't get to respond to this last series. This amount of money in this bill, a thousand dollars for a policy, how much of that could be used in the ways that Dr. Nelson would like it to be used? I mean, because that actually is our goal.

Mr. GREENSTEIN. Well, I think it is complicated. Surely the preventative services are key. Something particular like prenatal services, you want to make sure, though, if you are doing, as Dr. Nelson just said. If you have a prenatal screening and you find a problem, the person needs the insurance to be able to get the problem dealt with.

So you can't really separate the prenatal from the adequate follow-up coverage for the problems you then find.

Ms. CAPPS. Just to follow up on that just for a minute, Dr. Young. I nodded all of the way through yours. I am a public health nurse. I agree with you that the best kind of coverage is not necessarily the high end. And that those preventative dollars go such a long way. Your comment on preventative services to people, I think, is telling about why many of us are concerned, actually, about this health certificate, just in this one area.

And now I want to talk about what these tax credits or health certificates can help people do, and the drawbacks that it might have. Now, turning to those with basic health problems such as diabetes, some of those people would find health insurance policies in the individual market expensive, and some people, such as cancer survivors, may not even find an insurer who is willing to issue them a policy, though part of this, but only $75 million would go into the high-risk pools. That is not going to go far in this country for that topic.

But, even so, proponents of this approach argue it is better than nothing. They argue that vouchers are bound to help some people. I think also, though, and this is what I want to get at, there maybe a counter argument that such an approach could do more harm than good. And here, Mr. Greenstein, I want to ask you to elaborate on how a certificate or tax credit approach might actually undermine the system that we have today. For example, could it cause some to lose their coverage or raise costs for employers? And how would employer coverage perhaps be affected under a Health Certificate Act?

Mr. GREENSTEIN. Under this particular bill, the income limits and the asset limits are drawn very tightly. So a few employers would likely drop coverage as a result of the availability of the health certificates. Perhaps the only potential would be employers whose workforce is almost entirely a low-income workforce. But if you take a different kind of a approach, or a variant of the ap-

proach, I should say, like the Tax Credit Proposal in the President's budget, which has higher income limits, and is broader in terms of who could be covered.

Under that approach, there have been a number of analyses, I think Professor Gruber and others that have done that do find, they believe, there would be significant effects on employer coverage. Employers could reason that people could get these tax credits, so that these employers, especially smaller ones, deciding whether to offer coverage or not, it is more of an inducement not to offer coverage.

Another concern is that if you have a credit, another improvement in this bill over the President's proposal is this allows the certificates to be used toward the employer purchase. But, if you have a situation where an employee is faced with paying 30, 40, 50 percent of an employer premium cost, and the employer is, of course, pooling sicker workers and less sick workers, if you have a young healthy worker, that person with one of these tax credits might say, it is to my advantage to go purchase my own coverage in the private market.

Then, if the younger, healthier workers withdraw from the employer coverage, the employer is left with a pool of older and sicker workers, and therefore, the average cost for the comprehensive coverage the employer offers goes up. So under a number of those kinds of approaches, you—what you can have are winners and losers, and the younger healthier workers can be the winners, and the older sicker workers can be the losers. I think we should avoid approaches in which older and sicker workers are the losers. And one of my principal concerns about this bill is simply that it could start us down that path, as I said in my testimony, if future Congresses came back through, if you enact the Health Certificate bill, and raised the—let's let more of the uninsured get these health certificates. Then you would start to have more of a potential eroding of employer-based coverage.

Ms. CAPPS. Thank you. So this is a delicate balance you are talking about. Isn't it also possible that even those who currently have coverage and find themselves getting assistance through this certificate may find that they themselves are no better off, because their employer could just reduce their subsidy equal to the new certificate? Could you comment briefly on that? Because I want to ask you one more question.

Mr. GREENSTEIN. As I understand the bill, for the employee to use the certificate toward the employee share of an employer premium, the employer would have to pay at least 50 percent of the premium cost. There could lead some employers—again, I am only talking about those where the workforces are almost entirely low-income workers.

But, for those employers, if the employer now pays 60 percent or 65 percent, the employer could reason, well, I can reduce to it 50, and the employees are going to make up the difference through the health certificate.

Ms. CAPPS. Finally, it is a related topic. The recently passed Medicare legislation has a provision, the Health Savings Security Accounts. What effect do you—what effect do you think they would have on employer-sponsored coverage? This is not what we have

are having the hearing on today, but it is so closely related that I wonder if you can comment on legislation that has just recently been passed in the House.

Mr. GREENSTEIN. I am much more concerned about the impact of that than 2698. Again, 2698 has some features, as I mentioned, that if one stuck with them. I don't think it would do that much good in terms of covering that many more people. But, I don't think it would cause that much harm in terms of inducing a lot of employers to drop.

The provision the House recently passed has the Health Savings Security Accounts, but to use them the policies have to be relatively high, deductible policies, at least a thousand dollar deductible for family coverage.

The Joint Tax Committee estimates that over time, a majority of the employers in the country would move in that direction, so that you would have employers moving to higher deductible, and potentially less comprehensive coverage. It is true that employers could offer two options, a more comprehensive low deductible, and a less comprehensive higher deductible. But then you would get the adverse selection of the younger healthier workers moving to the higher deductible policies, and the average premium costs for the comprehensive policies might become prohibitive at that point.

So it is, again, this winners and losers thing. I think under that approach, there is a very high risk of significant losses for older and sicker workers occurring.

Ms. CAPPS. That was perfectly timed, wasn't it, Dr. Norwood. Thank you very much.

Mr. NORWOOD [presiding]. very well done. Mr. Towns, you beat me here considerably. Why don't you go next. You are now recognized for 5 minutes.

Mr. TOWNS. Thank you very much.

First of all, I want to thank all of you for being here. The chairman and I drafted this bill recognizing that it was not and is not perfect. We wanted to hold this hearing to have the opportunity to hear from you so that we might fix some of the things that need to be fixed, recognizing the fact that we are talking about a budget resolution of $50 billion.

Let me just go down the line, and ask each of you, what you would suggest that we fix at this point. What is not in the bill that should be? What is in there that should be taken out? I'll start with you, Dr. Young. If it is perfect in your opinion, please indicate that fact.

Mr. YOUNG. We can always argue for more money in it. We can always argue for particularly a continued strengthening of the risk pools, which we think are an important component. But, we think this is a very good start, modest as it is dollar-wise. And for those people who will find it of value, it will be of great value to them.

So I believe that you have made a very good start.

Mr. TOWNS. Thank you.

Mr. NELSON. Let's make sure it is aimed for those who need it the most, those who are not able to get health insurance now. And figure out whatever mechanisms it is to get it there. Let's make sure it is not so bureaucratically heavy, there is a lot of time and money and expense in the administration of the program. Let's

make sure that the dollars which are so precious do get to the people that need them the most.

Let's emphasize preventative care, clinical preventative services. Let's make sure that patients have the opportunity to get the care they need early, because it is going to cost less in the long run.

Mr. TOWNS. Thank you.

Mr. SHEA. I think on balance the committee would be better served, or the country would be better served by using this money in a different kind of vehicle, as I said. But I don't mean to disparage the notion here or the design structure entirely at all.

However, sensing as I do, how fragile employment-based coverage is, and the problems that Mr. Greenstein points out as potential, and I would say, I agree with his analysis, but thinking he may be underestimating the potential problems in this, I think this is more appropriate for an experiment or a pilot than a full-blown program.

And that is something that might be worth further exploring. One specific point. Unlike what happened in the Trade Adjustment Assistance Act, this is a capped benefit dollar amount. And it really, if it is going to be done, we think in a fair way to people, it needs to be done as a percentage of the premium as opposed to a capped dollar amount.

Ms. SPITZNAGEL. Our coalition is very sympathetic to having to be subject to the constraints of $50 billion. So we think that the bill is very good in regard to the fact that it had to stay within $50 billion.

In a perfect world, if there were more money available, there are some things that we would like to see changed. We would like to see the asset tests be eliminated, because we think that especially for this low-income population, it is very important that it be as easy as possible for people to enroll in these programs. And we see that as just one barrier that will divert their interest in this.

Perhaps some geographic adjustment for higher cost areas and age adjustment for older-aged workers. But also, increased subsidies for the risk pools, because the risk pools are a very, very important part of this system in keeping the premiums down, for those that are purchasing coverage in the individual market.

Mr. GREENSTEIN. Well, the $50 billion available in the budget resolution, like Gerry Shea, I probably wouldn't go this route. Because I think for $50 billion, one can make much more progress than one makes under this route given that most of the people who will get a subsidy, use the certificate, are people who are already insured.

And most of the people who aren't insured who will gain insurance with the certificates would tend to be the healthier workers. So I would refocus the $50 billion, as I indicated in my testimony, more on expanding. I would build on the twin pillars that we now have, employer coverage and public program coverage.

I particularly would expand the SCHIP block grant and let it cover parents. I would think perhaps about some kind of a targeted tax credit or other subsidy for small employers to make it more affordable for them to offer coverage. But I don't think I would want to put the bulk of the money into putting more people into trying

to buy coverage in the unregulated individual market, because of the difficulties that poses for older and sicker workers.

If one were, nevertheless pursuing this approach, I think the two most important changes to make would probably be one just mentioned by Gerry Shea, to have a fixed dollar certificate amount, that it is the same 5 years from now, even though health care costs are rising at double digit levels, wouldn't do that much. The percentage approach as opposed to a dollar approach would address that.

The second thing is, I would do it as a mandatory, even a capped mandatory program like SCHIP is, rather than a discretionary program. I don't think there is any assurance that after the first year, any of this money would ever be appropriated. The appropriators would have to find room within the appropriations caps.

Mr. NORWOOD. Thank you very much.

Mr. TOWNS. I'd like to ask another question and I would appreciate if each one of you would answer this in writing. Given that some Americans are considered uninsurable, if we do not promote the approach before us today, what options do we have to insure these individuals?

Mr. NORWOOD. If you ladies and gentlemen will submit that to the committee, we will be happy to get that to you, Mr. Towns, and distributed.

Ms. Eshoo, you are now recognized for 5 minutes.

Ms. ESHOO. Thank you, Mr. Chairman. And thank you to each one of the panelists for the important testimony today, and for the answers that you have given to the questions that have already been posed.

I would liked to ask the—the four that are to the left of Mr. Greenstein, if you agree with what he just recommended, in terms of shaping or reshaping what we have in front of us, given the amount of dollars that are available?

Because, you know, in terms of pillars or a foundation, we all agree that this is a black eye for our country. It is how we do it. Now, we have some money. We have the opportunity. And yet, I think if we get off on the wrong foot here, that we are going to blow a unique opportunity to make optimum use of the dollars. So can you react just quickly to what Mr. Greenstein said?

Mr. YOUNG. I don't agree. As I understand his point, it is that the subsidy will go to a number of people that now have coverage. As I look at it, these people are very low-income people. They are struggling to pay their share of the premium. And in many cases their employer is doing the same.

This raises to me an important issue of public policy, and of equity, equity of treatment of all citizens who are in very similar circumstances. As he would not give it to people who are trying to do the right thing and struggling, and give it to another group who has made the decision not to do it, and they are identical circumstances. So I do not agree with him.

Mr. NELSON. The American Medical Association thinks there is a better way to do it as well, by having advanceable tax credits available for both the employee and the employer. For some places, whether there is something like SCHIP that work, we should build on it. In our State it works very well. In other States it does not.

If something is working, let's use it. Let's look at some new ways. There is a point here that has not been brought out that needs to be underlined.

When we talk about the uninsured, some of these are people who are uninsured for only part of the year, that big number we talk about. It is as important to keep people insured, as to get those who are not insured again.

A lot of those folks that we are supposedly going to be double covering, wouldn't have the continuity of the care. Let's make sure that we don't forget them as well. So we would have a little bit different approach.

Mr. SHEA. I think the issue really here is what can you do given the amount of money on the table, as I understand the question you posed. I think Dr. Young makes a very important policy point. But, I don't think—I can't agree with him in this context of $50 billion. I think if you have got $50 billion, what you want to do with the stated goal is to increase coverage, there are better ways and more efficient ways to do it.

I think this approach is one that is definitely worth exploring. But, to do it as a nationwide program is going to cost a lot more money. That is why I raised, in answer to Congressman Towns's question, this is kind of thing which if a State wanted to step forward and say, we would like to experiment with this in a pilot, would be an interesting way, although even in that context there is some design issues.

Ms. SPITZNAGEL. We are very concerned about the idea of using this money to expand the income eligibility levels of SCHIP and Medicaid. There is strong evidence now that participation in means-tested programs is reduced as income rises. That has been found in the SLIMBY population, and in the QMB population, and it has been found in the higher-income populations that are eligible for SCHIP.

That is part of the reason why one-third to one-half of those eligible for Medicaid and SCHIP simply are not enrolled. They would be prefer to be receiving insurance in their workplace with their colleagues.

Ms. ESHOO. That is a very interesting thing that you just stated. I mean, I follow this very, very closely in my Congressional District, especially an San Mateo County where I was on the Board of Supervisors for 10 years, chaired our hospital board of directors, was directly involved with these populations.

I have never heard that, about that. Is it from a study?

Ms. SPITZNAGEL. Yes. I do have a study. I would be glad to submit that to you. There are a couple of studies, actually. And again, looking at the SLIMBY and QMB populations, they are at the higher of the low-income levels, and there are very low enrollment rates in those groups.

That data is readily available. I will be glad to get that to you. In addition, we believe that it is very important that private coverage be offered, because of the choice and portability that is available for those that are in this population.

Ms. ESHOO. I am going to need to ask you to stop there, because I only have 28 seconds left. I would like to ask Bob Greenstein something.

One of the troubling aspects of the legislation to me that, as it was being drafted, and that I have pointed out, is that we need to be targeted—we need to know whom we are targeting. And I don't really know whether we understand full well here what the profile of the uninsured population is.

I mean, some people talk about college students who don't want to pay for any insurance. Some say that they are mandated to by the college or university that they go to.

Are there more males than females? Are there more families less than singles. Are there more that are insured by their employers but not be able to take full advantage of it maybe for their families but only for themselves because they can't afford it.

What specific policies does the insurance industry have for poor people today? How competitive are those prices? When you look at the legislation, do you think that those are salient points? And do you think that we can cover them better with the dollars that are on the table?

Mr. GREENSTEIN. Well, I do think that we can. If I could relate this to the comment that previous panelist just mentioned. You know, SLIMBY and QMB are not the appropriate comparison here. Those are simple a buy-in to the Medicare premiums and deductibles that the Federal Government mandated States to offer through Medicaid. The States did not feel that was an appropriate State role, many of them have never really implemented it properly, often haven't done outreach and so forth.

What we do have, is we have coverage in most States, up to about twice the poverty line through Medicaid and SCHIP for children. And we have coverage in the median state, only up to 70 percent of the poverty line, for those children's parents. We have extensive research now, a long body of research that finds, that where the parents can get in the public program, whether it be SCHIP or Medicaid, the same program as their children, in a single plan, that that significantly increases enrollment by the children who are already eligible, and significantly increases utilization of necessary health care services by the children.

Now, we can debate what to do for people between 200 and 300 and 400 percent of the poverty line. But I think it should be a no brainer that we should cover the parents together with—the low-income parents together with their children through these public programs. That is where I would put the $50 billion.

Mr. NORWOOD. Thank you, Ms. Eshoo.

Ms. ESHOO. I wanted to thank the panelists for their answers.

Mr. NORWOOD. I also thank all of you for attending today. Obviously, this is a very interesting discussion. And we have $50 billion over 10 years. And we are—all of us want to get more people under some type of health care coverage. So my question to you that I would be very grateful for, in writing, because we just are going to run out of time here is: What is your program? If you don't like what we are doing here, why don't you tell us what you would do with $50 billion over 10 years, to get more people covered under health care.

Mr. Young, real quick. I am curious if you have given this any thought, or in fact any of you: Do individual subsidies work in a

health insurance market that basically today is geared to group pooling arrangements?

Mr. YOUNG. Yes, they would.

Mr. NORWOOD. How would this fit?

Mr. YOUNG. Yes, they would. About 10 percent of today get their insurance through the individual market, not through the group market. There have been a lot of studies that have looked at this. There have been some things thrown out today that are based on some studies that were very poorly designed.

My members sell the individual market. And we know that it works. Let me just give you a couple of statistics. We recently did a survey. We had 700,000 people, 1.3 million lives. The average premium was $2,000 for the individual, and was $4,000 for a family. There is an affordable product.

Mr. NORWOOD. May I interrupt as we go here? Are you telling me that the individual health care plans are competitive with group plans in terms of cost?

Mr. YOUNG. Yes, they are. But when do you the comparison, you also have to look at the nature of the benefit package. The ones I am talking about today are real full health insurance coverage. All policies will differ in terms of where they are out of pocket. But, are they competitive? Yes. Are they affordable? Yes.

Mr. NORWOOD. So you think the subsidy will work in a market where people will have to go buy individual policies, through we are trying to help them with some cash in which to buy that policy, where 70 percent, is that right, I think of the Nation is insured under a group pooling arrangement.

Mr. YOUNG. Yes.

Mr. NORWOOD. So you think this will work?

Mr. YOUNG. Yes. Ninety percent of the market, according to our survey, applied for insurance. And those who completed the application got the insurance. That other 10 percent is why we are so strongly supportive of the risk pools. That will deal with the people that have cancer, the people that have severe diabetes.

Mr. NORWOOD. Well, I am glad you ended on risk pools. I want to go there just a minute.

Dr. Nelson, in the last hearing that this subcommittee held on the topic of the uninsured, in which one of the witnesses here stated that in the last few years, the effects of guaranteed issue and community rating having made health insurance more unaffordable for small employers and individuals.

You also raised these issues in your written testimony, and state that the guaranteed issue and strict community rating has unintended outcomes. And I would like to give you a minute to explain that, if you would.

Mr. NELSON. Yes, sir, thank you. What happens is when these are put together, the guaranteed issue and the mandates and so forth, it gets very, very sick people, with very high risk, lots of cost, thereby increasing the premium for everyone.

That can have the unintended and undesirable consequence of forcing the less sick, the healthier and the younger out, because their premiums have gone up. So it kinds of works backwards. We are not sure that is the way to do it.

Mr. NORWOOD. So are you suggesting, then, that perhaps those that are sicker, and would be related higher, a better solution to that would be to utilize risk pools for them?

Mr. NELSON. Yes, sir. Something like that.

Mr. NORWOOD. I got questions all over the place up here.

Mr. Greenstein, my understanding is that Medicaid or SCHIP requires a State match, obviously it does. And you yourself noted that States are struggling to maintain their Medicaid or SCHIP programs. Are you aware, or maybe you haven't had time, but are you aware of any States that are willing to expand their Medicaid or SCHIP program at this particular time to cover the target population that we are trying to cover under H.R. 2698?

Mr. GREENSTEIN. Actually, Illinois just instituted an expansion on July 1st. I believe there is some expansion going on in Pennsylvania, and the State of Maine, just enacted a universal health coverage plan.

To be sure, in the midst of the current State fiscal crisis, it will be more difficult to get States to do this. I think as the economy recovers, and State budget situations improve, States would be more ready to do it.

The other quick point I would make is, if we were going to provide something closer to 100 percent Federal funding for something, rather than doing it for these health certificates, what I would rather do, and you take a step in this direction in the House Prescription Drug bill, is you essentially Federalize the prescription drug costs for the dual eligibles; the Senate doesn't, you do. Your bill is better than the Senate in that area.

Mr. NORWOOD. Oh, in a lot of places.

Mr. GREENSTEIN. I disagree on some of the others, but in that area I think it is. And if we can Federalize a larger share of the cost of the dual eligibles, then we free up room in State budgets to cover people like more of the parents through a Medicare SCHIP approach. I think that is the route to go.

Mr. NORWOOD. I see my time has expired. Mr. Strickland, I think you are next on your side. You are recognized for 5 minutes.

Mr. STRICKLAND. I want to thank you, sir. I have a question I want to direct toward Mr. Shea.

Mr. Shea, in your testimony, you briefly mentioned concerns with the implementation of the consumer protections in the Trade Act, in particular as the Bush Administration is interpreting the law, many of the protections Congress passed to ensure individuals can get decent coverage would not apply, as I understand it.

Could you please elaborate on the problems with how the Trade Act is being implemented, and what it may mean for consumers?

Mr. SHEA. Congressman, I said earlier that a number of us, maybe a lot of us in this room, spent a lot of time trying to develop an effective and workable tax vehicle to subsidize coverage, primarily for the unemployed when we first looked at this in the wake of the September 11, 2001 tragedy.

And we came up with a design which was an assignable, advanceable credit, which applied primarily to group coverage but would also apply to individual market coverage. And that didn't get enacted at the time, but was the model for the action under the

TAA, and it has several design elements that are—we think make it superior to design in this.

I have explained before that it is a percentage of premium not a capped dollar amount. But what you refer to is another dimension of this issue, which frankly has made some of us who participated in the earlier discussions much more shy about going down this road again, which is—we have a TAA benefit, which while it is due to do into effect next month, does not look like it is going to benefit many of the people it was intended to.

And part of the problem is, it is a result of the interpretation of the administration of admittedly ambiguous language, but their interpretation has minimized the number of people who would be eligible, because they have defined a certain phrase to mean that you have to have credible health insurance coverage just prior to your applying for the benefit, which means in many cases, months and months and years, after people had run out of coverage, I offer to use some of the bankrupt manufacturing corporations, in the heartland of the country as an example of that.

Mr. NORWOOD. Mr. Strickland, if you would yield. I am going to stop you not exactly on time, because the Prime Minister is going to be on the floor in 15 minutes, and we need to get there.

Mr. STRICKLAND. Absolutely. Thank you. Thank you very much, Mr. Chairman. I would like to address a question quickly to those who of you on the panel who are in favor of the bill. The expenditure of $50 billion appears to be inadequate to provide sufficient subsidy for the uninsured.

But the implementation of this program, the bureaucratic costs and the like, will no doubt reduce that figure. Are there any estimates as to how the implementation process, the setting up the process, the establishing of the needed bureaucratic functions and so on, reduce the original expenditure, and by how much?

Mr. YOUNG. I am not aware of any estimates that have looked at it. From our perspective on the insurance side, we think it can be made to work quite readily. But on the implementation government side, I don't have any data.

Mr. NELSON. Congressman, I don't know the answer in dollars. But I have a pager that floats when I drop it in the toilet, been run over by my car, been damaged but still works.

We ought to have the ability to do this. Your point is well taken.

Mr. STRICKLAND. Mr. Chairman, given the fact that we are needing to move on to get to Mr. Blair, and I don't want to dominate the time, I will yield back whatever time I have.

Mr. NORWOOD. I ask that the record be open for 30 days for responses to any questions by the members that they may submit in writing. And without objection, that is so ordered.

Mr. Waxman, you are now recognized.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

I want to ask Mr. Greenstein some questions. We are all concerned about the numbers of uninsured Americans. And I would like to ask you about the Medicaid and the SCHIP program in terms of their contributions to covering people who would otherwise be uninsured, and what the impact would be if we don't help the States to avoid cutbacks in coverage, to what might happen to the ranks of the uninsured if we put a cap on the Federal contribution

to Medicaid as advocates of turning Medicaid into a block grant program have proposed.

And, three, what the effectiveness would be of reducing the uninsured in this country if we built on Medicaid and SCHIP and spent our money there.

Mr. GREENSTEIN. Well, I think as I have been indicating throughout the hearing, I would concentrate on building on Medicaid and SCHIP. But, we can just look, for example, at the SCHIP's expansions after its enactment in 1997, and how successful it has been in reducing the number of uninsured children, and we can also look at these States that have expanded parent expansions, primarily in Medicaid, and a few cases with SCHIP waivers, using SCHIP funds in recent years.

Any they have made major progress in reducing the ranks of the uninsured. We pool everybody's risk through group coverage. By contrast in the individual market, the healthier people may be able to go buy policies, and the less healthy cannot, which as I would say, why I think the figures other panelists have used of 2,000 for individual coverage and 4,000 for family coverage in the individual market are not really directly relevant.

Those are the average premiums for those healthier than average people, who are the people who have succeeded in buying coverage in the individual market. But we need to be able to have programs that cover the less healthy as well as the more healthy. We need to pool risk. We need group coverage.

That is what both Medicaid and SCHIP and employer-based coverage do. I am very fearful of the effect that a block grant approach would have. It would pose significant difficulties during economic downturns, when more people lose employer-based covering and qualify for public coverage. It would pose significant difficulties if we have epidemics that were not foreseen, or we have medical breakthroughs that save lives but raise costs.

And we need to be able to have a structure that can cover these people and not run out of money halfway through the year because none of us in either the public or the private sector have been very good at predicting in advance, the percentage increase from year to year in health care costs.

Mr. WAXMAN. Is it safe to say you think that we would get more bang for our buck if we put it into shoring up these programs, either by the Federal Government helping the States with more of the costs or expanding eligibility than we would if we put it into a—they don't call it voucher, what do they call it, certificate program?

Mr. GREENSTEIN. Single main point of my testimony, yes. As I note in the testimony, estimates by Professor Gruber at MIT are that close to 90 percent of those who would use the health certificate subsidies are people who are already insured.

By contrast, if you look at, for example, Medicaid parent expansions of recent years, the estimates range from 6 to 30 percent in terms of the percentage of people who are already insured, meaning 70 to 94 percent in terms of those who were previously uninsured who gain coverage.

So both in terms of helping sicker people, but also just in terms of the efficiency, we have very little crowdout that we found or ad-

verse effect in terms of employer coverage. And we don't discriminate in favor of the healthier people, rather than as we distinguish from the less healthy when we expand a public program like Medicaid or SCHIP.

By contrast the certificate approach almost inherently results in a lot of leakage in terms of people who are already covered. It is inherently much easier for people who are healthier and whose premium costs would be lower to use the certificate to buy coverage, than for people who are sicker and whose premium costs in the individual market would, therefore, buy much higher to buy coverage.

Mr. WAXMAN. Would it be fair to say that had I been able to be here for the testimony, and if I had read your statement in advance, I would have had no need to ask you the questions I asked, except for the fact that it is good to have these issues clearly on the record in case anyone has any doubt about the points that you made?

Mr. GREENSTEIN. The only other thing I would add, which is really not in my testimony, and I am sure you know this, is regardless of one's view on things like the Health Certificate bill, I think there is a general bipartisan sense that SCHIP has made a lot of progress in covering children.

As you know, we are at risk of going backwards. Beyond the bipartisan bill that will hopefully be enacted next week, if that is all we do, we lose 370,000 kids by 2007, because of inadequate Federal SCHIP funding.

It only costs a few billion dollars to fix that. That is the very first thing we ought to do out of the $50 billion. We shouldn't go backwards in progress we have already made on a bipartisan basis in covering low-income kids.

Mr. NORWOOD. Thank you very much, Mr. Waxman. I thank all of the panelists immensely. We have talked about a lot of written questions that we would be very grateful for you to try to answer within the 30 days.

Thank everyone, and this hearing is now closed.

[Whereupon, at 3:50 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

RESPONSE FOR THE RECORD OF THE AMERICAN MEDICAL ASSOCIATION

Mr. Chairman and members of the Subcommittee, my name is John C. Nelson, MD, President-Elect of the American Medical Association (AMA). As you know, I testified before this Subcommittee on July 17, 2003. I am happy to provide the Subcommittee with the AMA's responses to the Subcommittee's follow-up questions.

QUESTION NO. 1: What is Congress' role in helping physicians help the uninsured?

Congress can assist physicians with providing healthcare to all Americans by establishing advanceable and refundable tax credits that are of a size inversely related to income (see attached AMA Policies H-165.920 and H-165.865). The tax credit must be large enough to ensure that health insurance is affordable. We believe that any federal spending on health care benefits should include a provision for tax credits (see attached AMA Policy H-165.861).

We recently established specific policy that Congress could use to better prepare the health insurance market for viable individual health insurance. These provisions were included as Appendix A of our written testimony that has been submitted to the Subcommittee. We are attaching these provisions to our written answers.

The AMA also supports the use of health care certificates to reduce the number of the uninsured and to assist individuals and families with their purchase of health

insurance. Chairman Bilirakis' legislation, H.R. 2698, the "Health Insurance Certificate Act," which would seek to reduce the number of uninsured Americans by providing subsidies to low and low-middle income families for the purchase of health insurance coverage takes an important step in accomplishing these critical goals. We believe that any health certificate system must ensure that lower income Americans would benefit from these certificates. Accordingly, the dollar value of certificates must be large enough to ensure that health insurance is affordable for most people. The certificates must at least be sufficient to cover a substantial portion of the premium costs for individuals in the low-income categories.

QUESTION NO. 2: Can you please explain how the uninsured population impacts doctors, hospitals, and other segments of the health system?

Uncompensated care to uninsured individuals is a strain on the entire health system. Physicians in particular, are compassionate professionals, who have great concern for unmet patient needs. Unlike hospitals, physicians receive no subsidy to account for uncompensated care they voluntarily provide to the uninsured. In fact, during 2001, 64 percent of physicians provided charity care to patients. This resulted in 7.6 hours per week of charity care, which was 16.1 percent of their total patient care hours.

Studies have demonstrated that individuals who lack health insurance forego needed medical care and are sicker when they do seek care. They visit emergency rooms and are admitted to hospitals in disproportionate amounts, raising medical care costs which are then passed on to an already overburdened system. As a result, the already overburdened health care system is forced to bear even higher costs to care for these Americans. In 2001, total uncompensated care was an estimated $35 billion.

QUESTION NO. 3: Can you please elaborate on why the AMA opposes benefit mandates?

Giving patients individual choice and enhancing consumerism (smart shopping) assists in keeping health insurance costs in check. The AMA supports mandates that are designed as patient protection measures. AMA Policy H-185.964 specifically states that we "oppose new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations. (CMS Rep. 2, A-99)."

QUESTION NO. 4: Do you have any comments regarding the provision of H.R. 2698 that deals with high-risk pools?

Provisions in H.R. 2698 refer to following the NAIC Model Health Plan for Uninsurable Individuals. At this time, we are in the process of reviewing the model law.

The AMA supports access to health care for the uninsured through state-run high-risk pools (AMA Policy H-165.979; H-165-995). Recently, through AMA's Council on Medical Services (CMS) Report 7 (A-03), the AMA determined that risk subsidies should be financed through general revenues (will become AMA Policy H-165.856). However, the Association has considered the questions, but not yet determined, whether it is better to use reinsurance and typical risk adjustment (payment to plans) or whether direct subsidies to high-risk individuals should be used, which would allow such individuals to purchase their more costly coverage from among the choices that everyone else has.

QUESTION NO. 5: In your oral testimony you argued that greater access to preventive medicine would be highly effective in driving down health insurance costs. How would H.R. 2698 help increase access to preventive medicine?

As previously discussed, H.R. 2698 would offer health care certificates to certain individuals. As long as the dollar value of certificates are large enough to ensure that health insurance is affordable for most people and at least sufficient to cover a substantial portion of the premium costs for individuals in the low-income categories, then such certificates could increase access to preventive medicine.

By assisting individuals with their purchase of health insurance, the certificates could allow individuals to chose plans that provide preventive services, such as annual examinations, blood work, and laboratory test that could assist in the diagnosis of health problems in their early stages. By diagnosing problems early-on, an individual can receive needed treatment and prevent complications from occurring and stop the further development of the disease.

An example of preventive care working for patients is prenatal care for pregnant women. Women who receive such care have fewer complications, less cesarean sections, and larger babies, which benefits both the mother and child. Preventive care also has been shown to work in the following areas:

- Immunizations (especially the pneumococcal vaccine for the elderly population)
- Smoking cessation
- Weight loss
- Stress relief

- Ensuring one is properly taking prescribed medications (such as medication for hypertension and diabetes)
- General patient education

KEY POLICIES ARTICULATING AMA PROPOSAL FOR THE UNINSURED

H-165.861 Use of Federal Surpluses for Uninsured Americans

AMA policy is that a portion of any increases in federal health care benefit spending be used to provide refundable tax credits, inversely related to income, for the purchase of health insurance to uninsured Americans, and that this be communicated to the President of the United States and to the Congress. (Res. 129, A-01; Modified: CMS Rep. 10, A-02)

H-165.920 Individual Health Insurance

Our AMA: (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;

(2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;

(3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, the AMA will:

(a) Support legislation that would provide the employer with the same tax treatment for payment of health expense coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health expense coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;

(b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;

(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage;

(d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health expense coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes; and

(e) To ensure that the health insurance plan purchased by the individual employee is sufficient to provide a basic level of health care and does not increase the probability that the employee will become uninsured, the AMA would work toward the establishment of the following guidelines: (i) minimum benefit requirements, including catastrophic protection, (ii) fiscal solvency of the plan, (iii) provision of basic consumer information, (iv) protection of the consumer from fraud, (v) guaranteed issue, (vi) guaranteed renewability, and (vii) rate reform;

(4) will identify any further means through which universal coverage and access can be achieved;

(5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health expense coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;

(6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;

(7) strongly supports legislation promoting the establishment and use of medical savings accounts (MSA)s and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance;

(8) continues to place a high priority on enactment of federal legislation to expand opportunities for employees and others to individually own health insurance through vehicles such as medical savings accounts;

(9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health expense coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;

(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health expense coverage;

(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;

(12) supports a replacement of the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families;

(13) encourages continued experimentation with and monitor the success of approaches to minimizing or compensating for adverse selection among the individually purchased and owned health expense plans available, including risk adjustment across plans, reinsurance pools, and limiting enrollment and disenrollment opportunities through such mechanisms as multi-year policy contracts;

(14) upon legislative enactment of Policy H-165.920(3a) and Policy H-165.920(6) ,the AMA should rescind Policy H-165.995(2)(a), which calls for tax code changes to allow persons paying the entire premium for their health insurance to deduct the full cost of their premium separately from their gross income;

(15) supports the use of tax incentives, and other non-compulsory measures, rather than a mandate requiring individuals to purchase health insurance coverage;

(16) seeks federal legislation to rescind Internal Revenue Service tax regulations requiring annual forfeiture of unspent funds in employer provided flexible spending accounts; and.

(17) believes that tax credits are preferred over public sector expansions as a means of providing coverage to the uninsured.

(BOT Rep. I-93-41; CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Res. 105 & 108, A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation; Reaffirmed: CMS Rep. 1 and 3; Appended: CMS Rep. 3, A-02; Reaffirmed: CMS Rep. 3, I-02)

H-165.865 Principles for Structuring a Health Insurance Tax Credit

(1) Our AMA supports for replacement of the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits, be guided by the following principles:

(a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided.

(b) Tax credits should be refundable.

(c) The size of tax credits should be inversely related to income.

(d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people.

(e) The size of tax credits should be capped in any given year.

(f) Tax credits should be fixed-dollar amounts for a given income and family structure.

(g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums.

(h) Tax credits for families should be contingent on each member of the family having health insurance.

(i)Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified MSA, and not for out-of-pocket health expenditures.

(2) It is the policy of the AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as such expenses are defined by Title 26 Section 213(d) of the United States Code.

(CMS Rep. 4, A-00; Reaffirmation I-00; Reaffirmation A-02)

H-185.964 Status Report on the Uninsured

Our AMA opposes new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations. (CMS Rep. 2, A-99)

H-165.995 Coverage of the Uninsured Through State Risk Pooling

Our AMA supports:
(1) the establishment in each state of a risk pooling program, in which all health care underwriting entities in the state participate, to provide adequate health insurance coverage at a premium slightly higher than the standard group rate to
(a) those who are unable to obtain such coverage because of medical considerations, and
(b) those with medically standard risks who could afford, but presently lack, access to such group coverage;
(2) the amendment of the federal tax code to
(a) allow persons paying 100 percent of the premium for health insurance coverage providing adequate benefits to deduct the full cost of their premiums separately from their gross income; and
(b) require employers to purchase group health insurance coverage from an entity participating in the state risk pool or, if self-insured, to participate in the risk pool if such a pool is available, in order to deduct the cost of their coverage as a business expense; and
(3) legislation to allow individuals to "buy in" to state employee purchasing pools or the Federal Employee Health Benefits Program (FEHBP).
(CMS Rep. J, I-85; Reaffirmed: Res. 241, A-93; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed by CMS Rep. 6, I-96; Reaffirmation A-99; Reaffirmation I-00; Appended: CMS Rep. 10, A-02)

H-165.979 Access to Health Care for the Uninsured

Our AMA
(1) reaffirms its support for ensuring access to health care for the uninsured through a combination of employer-sponsored coverage, other private approaches such as risk pools and the AMA proposed restructuring of Medicaid and Medicare programs which would provide health insurance coverage for those uninsured who are not otherwise covered through the private sector; and
(2) supports aggressively pursuing implementation of a program ensuring health care access for the uninsured as a high legislative priority beginning in the 101st Congress.
(Sub. Res. 28, I-89; Reaffirmed by CMS Rep. 8, A-95)

"APPENDIX A" IN AMA'S WRITTEN STATEMENT (REFERENCED IN QUESTION NO. 1)

The American Medical Association (AMA) supports the following principles for health insurance market regulation:

1. There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, and individual), geographic location, or type of health plan.

2. State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection.

3. Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges.

4. Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium.

5. Insured individuals should be protected by guaranteed renewability.

6. Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices.

7. Guaranteed issue regulations should be rescinded.

8. Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage.

9. The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically:
(a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed.

(b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options.

Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.

AMERICAN FEDERATION OF LABOR AND
CONGRESS OF INDUSTRIAL ORGANIZATIONS
August 15, 2003

The Honorable MICHAEL BILIRAKIS, *Chairman*
Subcommittee on Health
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

DEAR CHAIRMAN BILIRAKIS: Thank you again for the opportunity to present testimony for the subcommittee's July 17th hearing on H.R. 2698, the Health Insurance Certificate Act of 2003. Below are my responses to the follow up questions you have asked me to answer.

Question 1: Do you argue that a Health Insurance Certificate Program for low-income families may inspire some employers to drop coverage but an expansion of Medicaid in this same income bracket would not? If so, why?

As any program extends eligibility higher up the income scale—whether the health certificate or a Medicaid expansion—the probability of employers dropping coverage will increase. However, this is less likely to be the case with Medicaid, which has historically targeted coverage based on family composition and income, covering mostly children, and to a lesser extent, their parents. Despite federal authority to effectively raise the income guidelines without limit (using the Section 1931 authority discussed below), states' income eligibility guidelines remain very low. The median income eligibility cutoff for parents is just 71 percent of poverty, or $6376 annually for a single parent. In addition, very few programs cover childless adults, which would further limit the proportion of employers dropping coverage for workers. In contrast, H.R. 2698 allows individuals earning $25,000 annually to use the full value of the certificate toward family coverage (with partial value afforded to those earning no more than $34,000).

In addition, to restate the testimony I presented at the hearing, H.R. 2698 includes incentives for employers to either drop coverage entirely or to reduce the portion of the premiums that they subsidize. For employer sponsored coverage, H.R. 2698 provides for a certificate valued at a portion of what would be provided if the individual purchased coverage elsewhere. The legislation also allows individuals to choose between an employer's plan and coverage in the non-group market if the employer subsidizes less than 50 percent of the premium. Therefore, by either dropping coverage or reducing their contribution to the premium, employers could argue that they are giving their workers a more valuable certificate or providing them with more choices for coverage.

Question 2: My understanding is that Medicaid is basically like a cliff. You either qualify or you do not. This creates an incentive for individuals not to earn over a certain amount for fear of losing Medicaid coverage. H.R. 2698 does not have this problem. First, it provides a softer landing for those who now make more than what Medicaid allows for. In this case, they could have significant help with employee premiums or on the individual market. In addition, the proposal has a phase down policy. Is there a similar proposal to address these concerns under a Medicaid-style proposal?

Medicaid also allows for graduated income eligibility guidelines, primarily to accommodate individuals who move from welfare to work. Federal law allows for enrolled individuals to earn income above Medicaid eligibility guidelines in two ways. First, the Transitional Medical Assistance program allows individuals whose increased earnings would make them ineligible for Medicaid to remain enrolled for up to 12 months. Second, Section 1931 of the Social Security Act gives states the authority to disregard a portion of an individual's earnings in order to keep them enrolled in Medicaid. Prior to enactment of the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, states were limited in how much earnings they could disregard; however, Section 1931 eliminated those restrictions. Thirty-nine states have increased earned income disregards using Section 1931 authority (Kathleen Maloy, Kyle Anne Kenney, Julie Darnell and Soeurette Cyprien, "Can Medicaid Work for Low-Income Working Families?" published by the Kaiser Family Foundation, April 2002).

I would also disagree with the assertion that H.R. 2698 would provide "significant help with employee premiums or on the individual market." H.R. 2698 would provide between $300 and $1100 (40 percent of the value of a certificate for non-employer sponsored coverage), yet annual premiums for employer-sponsored family coverage averaged $7,954 in 2002 (Employer Health Benefits 2002 Survey, Kaiser Family Foundation and Health Research and Educational Trust).

Question 3: You propose a 65% subsidy versus set amounts. Do you know how much this would cost? Do you propose a 65% subsidy regardless of the amount of family income?

I do not know how much it would cost to provide a 65 percent subsidy to the target population in H.R. 2698. The cost would presumably depend on a number of factors, including how many individuals qualify for coverage, how many eligible individuals are able to purchase coverage with the certificate, and the cost of coverage. The AFL-CIO supports a 65 percent subsidy because it is more equitable than a fixed dollar subsidy. Such a fixed subsidy would discriminate against individuals who may be charged higher premiums because of factors such as their age, health status or where they live. For example, a report by Jonathan Gabel found that average premiums vary considerably by age, even among healthy individuals. Specifically, average annual premiums for individual coverage in 2000 for a 27 year old healthy male was $1584, while a healthy 55 year old male averaged $3756 ("Individual Health Insurance: How Much Financial Protection Does it Provide?" Health Affairs, April 17, 2002).

Again, I want to thank you for the chance to offer further comment on H.R. 2698 and I would be pleased to have further discussion on this and related subjects. While I believe that the funds available in the budget resolution to increase health coverage would be more efficiently and effectively spent in expanding existing public programs, e.g. Medicaid and SCHIP, H.R. 2698 recognizes the fragile state of employer-based health coverage and the need for public underwriting if such coverage is to continue to form the backbone of health care in America. I look forward to continuing the conversation.

Sincerely,

GERALD M. SHEA
Assistant to the President for Government Affairs

cc: The Honorable Sherrod Brown,
Ranking Minority Member, Subcommittee on Health,
House Committee on Energy and Commerce

RESPONSES FOR THE RECORD FROM DEDE SPITZNAGEL, BOARD MEMBER AND EXECUTIVE VICE PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL, COALITION FOR AFFORDABLE HEALTH COVERAGE

Question 1. Why does the Coalition support helping uninsured people get private coverage rather than expanding Medicaid or S-CHIP?

Response: The Coalition for Affordable Health Coverage (CAHC) believes that encouraging and enabling people to have private health insurance rather than expanding welfare with more Medicaid is wise policy for the following reasons.

Assisting people with private coverage is less expensive than providing public health care. Providing individuals with a $1000 certificate or a family with a $2750 certificate to purchase coverage is less expensive than paying for the Medicaid infrastructure and medical services needed by the individual in any given year.

Giving individuals and families access to private health insurance means they have more choice. They can select insurance that reflects their family's needs and there are more doctors who will take privately insured patients than will take Medicaid patients.

Expanding Medicaid eligibility may not work. Already, about 30% of the uninsured are eligible for Medicaid. Why aren't they using it? There are several reasons. Some simply don't know that they have this option. Some are afraid of immigration authorities. More than 25% of the uninsured are from other countries and may be unwilling to come forward for Medicaid because they fear immigration authorities, either because of their own situation or because of someone in their household. Finally, many of the "working poor" don't want to be on welfare. They are working very hard to stay off the public rolls and prefer to go without insurance rather than participate in Medicaid, at least until a medical crisis occurs. For many in this 30% cohort of the uninsured, getting assistance to participate in the private insurance market would be more appealing.

To the extent possible, we believe that government should encourage the private sector to provide insurance and health care, rather than the public sector. The free

enterprise system is a tremendous strength of our society and, where possible, should be supported, not supplanted.

Question 2. In the last hearing this Subcommittee held on the topic of the uninsured, your organization's President, Mary Grealy, stated for the hearing record that evidence suggests that we are reaching the limits of effectiveness in reducing the number of uninsured through federally funded programs such as SCHIP and Medicaid. Can you provide some reasons as to why this is the case, and how H.R. 2698 might help to address the problem?

Response: Medicaid and S-CHIP are valuable public programs for their intended purposes—very low-income families. However, evidence suggests that we are reaching the limits of effectiveness in reducing the number of uninsured through the S-CHIP and Medicaid programs.

Only about half of individuals currently eligible for Medicaid and S-CHIP actually participate. A number of reasons have been cited for low participation rates including the fact that participation rates of means-tested public insurance programs decline as incomes rise. A large number of those not participating are those with incomes too high for Medicaid eligibility, but low enough to qualify for S-CHIP. Families with incomes just above the poverty level are often working full time and are more reluctant to receive their health care through a public program. This pattern of lower participation among higher income persons is also evident in other government health care subsidy programs, including the Qualified Medicare Beneficiaries (QMBS) and Specified Low-Income Medicare Beneficiaries (SLMBs) programs. Researchers have concluded that substantial outreach is necessary to overcome barriers to participation, such as the possible stigma associated with public programs.

These data suggest that eligibility alone, without considerable investment to remove existing barriers to participation, will not efficiently increase participation in Medicaid and S-CHIP. Many eligible individuals in the higher income categories of Medicaid and S-CHIP, as well as income categories under consideration for Medicaid and S-CHIP expansions, are connected to the workforce. In fact, about 15% decline overage available from their employers. Therefore, solutions involving employer insurance may be more effective in increasing coverage rates for these populations.

The health certificates created by H.R. 2698 would be more desirable than these restrictive public programs for much of the uninsured population because the certificates would allow recipients to choose the insurance that best suits their needs, including their employer-offered health plan. The low-income working uninsured will be more likely to pursue enrollment in a health coverage option if they have a choice other than the public programs.

Question 3. Do you agree that a Health Insurance Certificate Program for low-income families may inspire some employers to drop coverage but an expansion of Medicaid would not?

Response: The concern that employers may drop health coverage if subsidies are provided to their uninsured workers can exist regardless of whether subsidies are provided through "health insurance certificates," tax credits, or through expansions in public programs. The key issue is to include design elements that reduce the likelihood that employers will drop coverage, as H.R. 2698 does.

If an employer is currently offering health insurance to her employees, and a government subsidy is made available to only low-income employees (as in H.R. 2698), the employer would be hard pressed to drop health insurance altogether or reduce her contribution level, since those not qualifying for the low-income subsidy would be left with a gap in resources.

Furthermore, employers have incentives and a strong desire to provide health insurance to their workers if it is affordable. Providing health insurance—the most sought after employer benefit—helps a company compete for and retain higher quality employees, and it helps keeps their workforce productive. CAHC believes that a subsidy for purchasing private health insurance could actually encourage more employers to offer health insurance; especially those employers who do not now offer to subsidize coverage because they do not have a crucial number of employees that can afford their share of the premium.

Question 4. My understanding is that Medicaid is basically like a cliff. You either qualify or you do not. This creates an incentive for individuals not to earn over a certain amount for fear of losing Medicaid coverage. H.R. 2698 does not have this problem. First, it provides a softer landing for those who now make more than what Medicaid allows for. In this case, they could have significant help with employee premiums or on the individual market. In addition, the proposal has a phase down policy. Please comment on this distinction between the Medicaid approach and the approach in H.R. 2698.

Response: In previous testimony before this committee, a representative from the Institute of Medicine noted that all of the enrollment and eligibility hoops—including hard income cut-offs—result in an average Medicaid tenure of five months. Many individuals between 100 and 200 percent of poverty have incomes that fluctuate greatly throughout any year. Hard income cut-offs in the public programs not only disrupt continuity of care, but they also create a disincentive for people to pursue higher paying jobs, and in some cases, any job at all.

H.R. 2698 encourages continuous health care coverage in a number of ways. In addition to encouraging them to enroll in their employer plan which in itself facilitates coverage stability, it allows individuals to receive at least some amount of a phased-down subsidy as their income rises, instead of abruptly cutting off individuals when the exceed income eligibility.

Question 5. In your written testimony, you state that CAHC has serious reservations about the methodologies used in assuming displacement or "crowd out" of employer coverage. Can you please elaborate on this and provide some examples?

Response: CAHC has never fully understood nor accepted the methodology used by budget and policy analysts that predict that employers will drop health benefits packages when a government certificate or tax credit is created. In order to compete for good employees, employers have to provide good benefits.

Past history has demonstrated that employers offering childcare subsidies did not stop offering this benefit just because the government created a childcare tax credit. Health insurance is even more primary and embedded in our employee compensation packages.

In addition, large self-insured employers would run afoul of anti-discrimination laws if they stop offering coverage to their low-income workers. This in not an excludable class for the purpose of benefits.

Question 6. In Mr. Shea's written testimony, he states that employer premiums may rise as a result of younger, healthier workers opting out of an employer plan for a less comprehensive plan in the non-group market. However, H.R. 2698 states that if the employer contributes at least 50% of the cost of the premiums towards the employee's coverage, then the employee is only eligible for the employment subsidy, not the individual market subsidy. And if the vast majority of employers are contributing at least 50%, which they presently are, is this likely to occur?

Response: Historically, coverage through employer-sponsored plans is more attractive to workers than individual coverage. Employers subsidize premiums, making comprehensive coverage much more affordable to their employees. In addition, employees often have access to a company benefits manager who helps them sort through claims and acts as a go-between for the employee and insurer.

HR 2698 does not allow employees to leave their group policy when they work in companies that have more than a 50% subsidy. Although such employees would be highly unlikely to find individual market policies that could compete with a 50% subsidy from the employer, this is not even an option under this bill.

Since most companies pay at least 50% of their employee's premium costs, there should be little concern about some exodus of younger workers into the individual market.

Question 7. Your organization supports providing assistance to the working uninsured. Why does your organization support offering help to this group when they already have tax benefits and/or employer assistance?

Response: Actually, most of the uninsured do work but don't have access to employee-based health insurance Seventy-five percent work for employers who are unable to offer benefits. Our present patchwork of tax incentives and public programs leaves them out in the cold. Certainly, they don't have the disposable income to participate in tax-sheltered savings programs like MSAs. In addition, they earn too much to participate in government welfare programs like Medicaid. To further exacerbate their problem, those who lack health insurance often end up paying the highest prices for medical care because they are not pooled into a group that has negotiating leverage. They can ill afford this situation. If Congress wants equity in ensuring access to health care services, the working poor need assistance.

A small segment of the uninsured do have access to health insurance through their employers (25%) and can benefit from the positive tax treatment afforded to employers and employees. The problem is that many of these individuals simply cannot afford to pay their share of the employer-provided insurance. Fortunately, H.R. 2698 provides a partial certificate to allow these workers to participate in their company's plan

Question 8. H.R. 2698 is going to help a new group of individuals—the so-called working poor—get health insurance. What do we know about this group, and how do you believe they can best be helped?

Response: We know quite a lot about the uninsured. Here is a composite of the facts relative to the uninsured that fall into the category of the "working poor."

- Income: 41% of the uninsured earn under $20,000 per year. About 31% make less than $15,000.
- Employment: More than half (55%) of the uninsured work full-time, all year round. Only 18% have no attachment to the work force. More than half (61%) work for small firms (less than 25 employees).
- Age: More than half are 19 to 34 years of age, an appealing age group for private insurers.
- Employers: The uninsured are most likely to work in the following fields: agricultural, personal service, construction, retail, and entertainment.
- Ethnicity: The uninsured are disproportionately minority, with Hispanics leading the list (35% of Hispanics are uninsured).
- How long without coverage? Many of the uninsured (45%) are without coverage for less than fours months. However, CBO found that "people with less education are more likely than higher educated people to experience long uninsured spells." This tells us that the "working poor" are likely to be uninsured longer periods and that crafting policy targeted toward the long term uninsured will mean that lawmakers are also targeting assistance to the lower income or "working poor."
- Health Status of Uninsured: CBO reports that only about 5% of the uninsured have poor health.

There are many complexities in understanding the characteristics of the uninsured. However, the above demographics convince CAHC that a large percentage of the uninsured fall into this "working poor" category. Many are young and healthy enough to get reasonable insurance policies within the private market. They are motivated to work and be independent, rather than rely on government-provided health programs. In fact, almost ⅓ of the uninsured qualifies for Medicaid or SCHIP but do not participate. CAHC believes that bills such as HR 2698 which assist the working poor in obtaining private coverage would take a big bite out of the number of uninsured in the United States.

Question 9. How would you characterize the state of the individual market? How would a health certificate program affect it?

Response: Nationwide, around 15-17 million people obtain coverage through the individual market, versus more than 175 million through employer-based coverage. There are at least two reasons for the relatively small size of the individual market. First, post WW II tax incentives helped create a tradition of employer-provided coverage in our country that continues today. For most people, this works quite well. Second, some states have made it impossible for a thriving individual market to exist in their state, making this health insurance option unavailable to those who could use it. Requirements like such as community rating and guaranteed issue make the individual market artificially expensive. For example, the state of New York has guaranteed issue and community-rated individual health coverage. The result is that the average cost is more than $1000 per month for family coverage.

Despite these problems there is encouraging news. In states where the market is free to operate, there is healthy competition and the individual market provides comprehensive and flexible health plan options for individuals. States with "safety nets" like high-risk pools for individuals with serious health issues provide an environment for health plans to compete most effectively on price, quality, and innovation. For example, if someone leaves New York and moves next door to Connecticut, they will find that a standard risk individual can obtain comprehensive health coverage, with prescription drug coverage, for under $200 a month.

Health care tax credits would directly impact the ability for lower income families to afford coverage through the individual market. Six out of ten uninsured families have a working head of household employed through a small employer who does not provide health coverage. These individuals are forced to obtain health coverage with no financial assistance and without the tax advantaged status employers receive. Further, less than 5% of individuals are medically uninsurable, so 95% of uninsured families would have no problem obtaining private coverage. Tax credits provide the assistance these families need to afford basic, comprehensive medical coverage.

Question 10. As you know, a large percentage of the uninsured are dependents of workers and while the workers may be able to afford coverage for themselves, they cannot afford the higher premium for family coverage. Could you please comment on this portion of the uninsured population, and comment on how the certificate could help this segment?

Response: Many people inside the beltway assume that most employers contribute to family health insurance coverage in the same way the federal government does.

The fact is that many employers, particularly small employers, pay some or even all of the employee's coverage but none of the cost of dependent coverage.

Dependent coverage alone can easily cost $500 per month or more, which could be a huge part of a low-income worker's paycheck, even if the employer is paying all of the cost of coverage for the employee. One of the features of the proposed Health Certificate legislation is to provide assistance with premium costs for dependents that obtain coverage through an employer-sponsored health plan. This assistance would defray the large deduction these workers face out of each paycheck for dependent medical coverage and would allow the worker to combine the employer contribution and the health certificate with their own funds to get the whole family insured.

Allowing low-income employees to supplement their employer's contributions with a health certificate would help families to be insured together. Those who would benefit the most from a certificate in an employer plan are lower income employees, the working poor and "near-poor" whose employers pay some of the employee premium but little if any of the dependent premium—people who cannot now afford to come up with "their share" of health insurance premiums. For these individuals and families, the current employer contribution is not enough to enable them to purchase coverage, and because they are in low or zero tax brackets, the tax exemption on employer paid premiums does not benefit them. If they were able to combine their employer's contribution with a health certificate to help them pay their share of health insurance premiums, they would be much more likely to be able to afford coverage, and, it would empower individuals to select their own place of purchase, rather than having it imposed on them by the government.

Of course, a number of small employers don't provide any health insurance benefits. For low-income employees who work for these employers, the health certificate will be essential to their being insured at all. The legislation takes into account that these working poor don't have any assistance with the cost of coverage, and provides a larger certificate than that provided to those who have employer-sponsored coverage.

Question 11. Mr. Shea argues that employers might drop coverage. Mr. Greenstein states in his testimony the income and asset limits are such that it is unlikely that employers would drop coverage because the credit would not be available to all of their workers. There is also the preferred tax-treatment of health coverage benefits. H.R. 2698 would provide partial subsidies for employment-based insurance. Moreover, I do not know how this argument is any different than a subsidy under Medicaid or S-CHIP. Could you please comment on this?

Response: It is highly unlikely that employers would drop coverage if a health certificate or other subsidy were available to low-income workers. Employers have different types of workers, and not all are low-income. Dropping their health plan could mean the loss of key employees, as health benefits are one of the most important factors in attracting and retaining good employees, as well as loss of the owner's coverage.

There has also been some concern expressed that employers would contribute less for certificate-eligible employees, increasing the potential cost to the government. This would be unlikely, as employer contributions cannot legally be discriminatory in this manner, and they would not want to run the risk of losing key employees if they lowered their contributions for everyone. It is frankly unlikely to happen, and is not any more likely to happen than it would under Medicaid or SCHIP.

Some have speculated that certificate-eligible employees are unlikely to leave an employer plan to purchase less expensive coverage in the outside market with a health certificate. The value of the health certificate relative to the employer's contribution would make that an unattractive option, since the employer contribution in most cases would be larger and the employee would lose the employer contribution in the outside market. And since employers need to keep credit-eligible employees in the plan to meet plan participation requirements, employers are unlikely to reduce their contributions or benefits so dramatically that an employee would be tempted to leave the plan with their health certificate.

HOME INSURANCE ASSOCIATION OF AMERICA
August 19, 2003

The Honorable MICHAEL BILIRAKIS
U.S. House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

DEAR CHAIRMAN BILIRAKIS: I appreciated the opportunity to testify before your committee last month on behalf of H.R. 2698, "The Health Insurance Certificate Act of 2003." As a follow up to the hearing, the committee has asked for answers to some additional questions. The answers to these questions are attached to this letter.

Also attached is the Health Insurance Association of America's proposal for dealing with the growing problem of the uninsured in America, called InsureUSA. InsureUSA is a comprehensive set of public policy recommendations for guaranteeing access to affordable health insurance coverage to all Americans.

If you have any other questions or would like to discuss these proposals further, please call me at 202-824-1682.

Sincerely,

DONALD A. YOUNG, MD
President

QUESTIONS FOR DR. DONALD A. YOUNG, M.D.

Question 1. Do you agree that a Health Insurance Certificate program for low-income families may inspire some employers to drop coverage but an expansion of Medicaid would not?

The extent of "crowd-out" is not determined by whether the alternative is public or private, but the degree of overlap in eligibility, the relative benefit levels and cost to enrollees, and whether individuals are able to apply any subsidy towards their existing private coverage. For individuals with family incomes below the federal poverty level, crowd-out should not be a significant issue in either case—few have employer-sponsored coverage to begin with.

For the near-poor or "working poor," or those with family incomes roughly between 1 and 2 times the federal poverty level, the situation is more complicated—a significant number in this income range are enrolled in or have access to employer-sponsored coverage. Using SCHIP to buy into employer-sponsored plans is generally impractical; to take advantage of any expansion, workers would have to drop their employer-sponsored coverage—the Health Insurance Certificate program would allow eligible workers to stay with their private plans. SCHIP is typically provided without a significant premium—the Health Insurance Certificate program would require participants to pay at least 30% of the premium. On balance, for individuals with incomes above the federal poverty limit where crowd-out becomes a serious issue, we believe that a Health Insurance Certificate would be much less damaging to the private employment-based system than Medicaid or SCHIP expansions.

Question 2. My understanding is that Medicaid is basically like a cliff. You either qualify or you do not. This creates an incentive for individuals not to earn over a certain amount for fear of losing Medicaid coverage. H.R. 2698 does not have this problem. First, it provides a softer landing for those who now make more than what Medicaid allows for. In this case, they could have significant help with employee premiums or on the individual market. In addition, the proposal has a phase down policy. Can you comment on the comparison?

Any proposal for providing assistance based on income must face the question of whether eligibility should be phased out gradually, or simply terminate with a cliff at a particular income threshold. One advantage of certificates, vouchers or tax credits is that their value may be graded down gradually, making the "soft landing" phase-out much more practical. With Medicaid or SCHIP the only realistic way to structure an eligibility phase-out is with an income-graded premium. We believe the implementation of an income-graded premium will prove challenging, since the Medicaid and SCHIP programs are not fundamentally designed for a premium, and such an approach delays "mainstreaming" the working poor into the same health plans that their neighbors and co-workers use.

Question 3. In Mr. Shea's written testimony, he states that employers premiums may rise as a result of younger, healthier workers opting out of an employer plan for a less comprehensive plan in the non-group market. However, H.R. 2698 states that if the employer contributes at least 50% of the cost of the premiums towards the employee's coverage, then the employee is only eligible for the employment sub-

sidy, not the individual market subsidy. And if the vast majority of employers are contributing at least 50%, which they presently are, is likely to occur?

Health plans, like any other employee-benefit program, are part of an overall compensation strategy, and affect high-wage workers as well as low-wage workers. Research shows that low-wage workers are much more likely to be offered health coverage if there are also high-wage workers in the firm, suggesting that this is a fringe benefit that is primarily offered because high-wage workers demand it. Employers are unlikely to raise their contribution requirements, which would affect their entire work force, simply because a relatively modest subsidy is available to their low-wage workers. To the extent any change is made to employee contribution levels, it will likely be offset by other benefit enhancements or higher wages.

Question 4. What are the specific problems driving high costs for health insurance for small businesses and individuals?

According to a survey HIAA conducted earlier this year, 31% of all Americans rated cost as the most important health care issue, slightly ahead of those who say the uninsured or Medicare prescription drug coverage ought to be policymakers' top concern. The survey also shows that people with private insurance tend to underestimate the amount of insurance premiums paid by their employer, and to overestimate the amount of health care spending that comes from their own pocket. HIAA put together a chartbook outlining the reasons health care premiums are rising. It is attached to this letter.

Question 5. Can you please identify the different segments of the uninsured population that would benefit from H.R. 2698? Of these different populations, which would you expect to exhibit the highest utility, and how would that impact the overall costs to the healthcare system?

Individuals below the federal poverty level who are not eligible for Medicare or SCHIP. A minority of this group will be offered access to employer-sponsored plans, though their employment will likely not be stable. The Health Insurance Certificate will allow them to buy into employer plans when available. Others will be able to buy individual coverage, though the need to pay 30% of the premium will be a barrier to some.

The working-poor not offered employer-sponsored coverage. Individuals and families in this category have a meaningful, albeit limited, income—paying 30% of the premium is a much less significant barrier for them.

The working-poor with access to employer-subsidized coverage. This group is likely to benefit the most from the Health Insurance Certificate program. The availability of an employer subsidy has already reduced the cost of coverage—the ability to apply a government subsidy to the remainder of the premium will make coverage significantly more affordable.

Question 6. As you know, a large percentage of the uninsured are dependents of workers—and while the workers may be able to afford coverage for themselves, they cannot afford the higher premium for family coverage. Could you please comment on this portion of the uninsured population and comment on how the health certificate could help this segment?

This is an important segment of the uninsured population. Allowing the Health Insurance Certificate to be applied towards the cost of family coverage in an employer's plan will be of direct benefit to these families.

Question 7. As you probably know, states such as Kentucky, Washington, Idaho, and New Hampshire have repealed guaranteed issue requirements and put in high-risk pools instead. Could you please provide some reasons why states have chosen to move in that direction?

Guaranteed-issue requirements, particularly in conjunction with restrictions on premium rating, increase the cost of coverage for everyone in the market. High-risk pools are an effective method of capping the cost of coverage for individual with serious medical conditions, without undermining the private market for other consumers. Guaranteed issue effective imposes a hidden tax on healthy consumers to reduce premiums for high-risk individuals; state pools provide an efficient mechanism for funneling a subsidy to high-risk individuals from a broader, more equitable tax base.

Question 8. Do you think H.R. 2698 provides for adequate consumer protections?

The bill offers adequate protections by requiring that the certificate be applied towards HIPAA creditable coverage ensures that eligible individuals will be buying a primary health plan, rather than supplemental coverage. Individual insurance is extensively regulated by the state; insured employer-sponsored coverage, as is found among small employers, is also governed by state law. Large employer plans are limited by the demands of high-wage workers.

Question 9. How would you characterize the state of the individual market? How would the health certificate impact it?

The individual insurance market is a vital source of coverage for millions of Americans. It is, however, in a very real sense a residual market for those who are not offered coverage at work. As such, it is fragile—ill-conceived legislation, such as guaranteed-issue and community-rating requirements, can easily damage or destroy it. The proposed Health Insurance Certificate program would bring additional people into the individual market, but would be unlikely to change the fundamental nature or economics of the market.

Question 10. Mr. Shea argues that employers might drop coverage. Mr. Greenstein states in his testimony that the income and asset limits are such that it is unlikely that employers would drop coverage because the credit would not be available to all of their workers. There is also the preferred tax-treatment of health coverage benefits. H.R. 2698 would provide partial subsidies for employment-based insurance. Moreover, I do not know how this argument there is any different than for a subsidy under Medicaid or SCHIP. Could you please comment on this?

Replacing private coverage is not a significant issue below the federal poverty line. Above the federal poverty level, Medicaid or SCHIP expansions would be more damaging to the employment-based system than a dollar-amount subsidy—particularly a subsidy than can be applied towards employer-sponsored plans. It is absolutely vital to avoid undermining the employment-based system, and as the details of any legislation are worked out this should remain a focus. However, I would note that the first and most important step—allowing the credit to be applied towards employer plans—has already been taken, and that the income and asset levels involved are relatively modest. Very few employers will find that all of their workers qualify for the Health Insurance Certificate, which should minimize the number that would be tempted to drop their coverage.

INSUREUSA

COVERING AMERICA'S UNINSURED

Covering the Uninsured: HIAA's InsureUSA Proposal

Tens of millions of Americans still lack health insurance. To solve this enormous problem, Congress must act to help these Americans afford the health care coverage that they, and their families, need. HIAA's InsureUSA proposal (www.insureusa.org) offers a series of practical initiatives that would provide coverage for most of the nation's uninsured.

The time is ripe for action. The number of uninsured Americans grew steadily during most of the 1990's. While there was a two-year hiatus at the peak of the economic expansion, this was a brief pause in a steady trend that had lasted more than a decade. The growth in the uninsured has resumed with the current economic downturn. According to the U.S. Census Bureau, over 41 million Americans have no health insurance coverage.

To increase coverage, health insurance must be more affordable for more Americans. The main reason that Americans are uninsured is because they cannot afford health insurance coverage. Many well-intentioned attempts at insurance market reform have had the effect of increasing the cost of coverage and increasing the net number of individuals without health insurance. Reforms, therefore, should both reduce the costs of health insurance and provide financial support for those who otherwise cannot afford coverage.

Multifaceted problem requires multifaceted approach. While affordability is the primary reason people lack health coverage, the uninsured have many faces. Rather than advocating a singular approach to insuring more Americans, we are advocating a 5-point program designed to attack the underlying reasons that people are uninsured.

A strong, vibrant private health insurance market should remain a cornerstone of our health care system. Expanded coverage must be achieved through means that do not threaten the coverage of other Americans or damage the existing private market. Competitive markets remain the most efficient and responsive mechanisms to provide consumers with coverage. Regulations that stifle innovation, flexibility and responsiveness to consumers should be strongly discouraged. For example, nothing in the proposal should be interpreted as favoring public coverage over private or as requiring health insurers to operate in markets in which they have chosen not to.

Reforms should make health coverage more affordable within the context of the employment-based private health care system, rather than destroying it. Nine in every 10 Americans with private health coverage get their health insurance through their employer. While the percentage of Americans with employment-based health cov-

erage has declined somewhat in the wake of the recent economic slowdown, steady increases in coverage during most of the 1990s demonstrate the strength and resiliency of this system.

The new initiative should be financed with broad-based funds. Rather than recommending specific sources to finance this series of initiatives on the uninsured, HIAA recommends that funding decisions be left to state and federal policymakers. Policymakers should be encouraged to finance these proposals with broad-based funding sources. For instance, stable, on-going funding is critical to the success of any risk pool. Policymakers should consider general revenues, as well as state funds related to health (such as tobacco-related recoveries) as possible financing sources.

KEY ELEMENTS OF INSUREUSA

The InsureUSA proposal has 5 key components:

- Extending the safety-net for Americans living below the federal poverty level
- Giving the working poor the help they need to buy their own coverage
- Guaranteeing access to coverage for uninsurable individuals through broad-based funding for state high risk pools
- Encouraging greater coverage for individuals and small businesses through enhanced tax incentives
- Extending and enhancing Archer Medical Savings Accounts (MSAs)

I. COVERING VERY LOW-INCOME INDIVIDUALS

Conceptual approach: Extend the current social safety net obligation currently fulfilled by Medicaid to include all adults below 100% of the federal poverty level, regardless of family structure. Medicaid, the joint state-federal program designed to provide health insurance coverage to low-income Americans, does not extend coverage to all poor people. For example, married couples without children and men are generally not eligible for Medicaid coverage unless they are disabled. A government-sponsored program is proposed based on the assumption that individuals with family incomes below 100% of the federal poverty level have at best a tenuous connection with the work force (only 17.5% of non-elderly Americans in this income range have employment-based coverage).

Target population: Individuals and families with incomes below 100% of the federal poverty level who are not eligible for other federal or state subsidized health insurance coverage such as, but not limited to, Medicaid, Medicare or the Children's Health Insurance Program (S-CHIP).

Key elements of the proposal:

- Expansion of public program to provide health insurance to all individuals with incomes below 100% of poverty.
- Funding and structuring program are both fundamentally government responsibilities.
- Joint federal/state funding and program structure would be based on the S-CHIP program.
- States would be given significant flexibility with regard to coverage, benefits and program structure, as in the current Health Insurance Flexibility and Accountability (HIFA) demonstration initiative.
- States would be encouraged to use program funds to subsidize coverage under private employer-sponsored health plans for poor individuals eligible for such plans.

II. COVERING THE WORKING POOR

Conceptual approach: Subsidize the cost of private health insurance coverage for the near poor and working poor. Subsidized private coverage is proposed because this population segment largely consists of low-income working individuals who in many cases have access to employer-sponsored coverage (45% of non-elderly Americans with family incomes between 100-200% of the federal poverty level have employment-based coverage) and it is neither necessary nor desirable to replace private coverage with a government-sponsored program. The subsidy should be large enough to make coverage substantially more affordable for low-income individuals, but should not be so large as to encourage over-insurance. Because the cost of coverage varies significantly by age, family size and geographic location, it is critical to provide a subsidy that is equitable for individuals in different situations.

Target population: Individuals and families with incomes between 100% and 200% of the federal poverty level who are not eligible for current subsidy programs (e.g., Medicaid, Medicare or S-CHIP).

Key elements of the proposal:

- A refundable tax credit or direct federal voucher provided to individuals with incomes between 100% and 200% of poverty based on taxable income.
- If eligible individuals have access to an employer-sponsored plan, the credit or voucher would be used for the employee contribution.
- If no employer-sponsored plan is available, then the credit or voucher may be used towards any coverage meeting the Health Insurance Portability and Accountability Act (HIPAA) definition of "creditable coverage" for which the individual is eligible.
- If a tax credit is used:
  - It should be equal to 60-75% of the premium. A percentage of premium credit allows for variations in cost by age, family size and location.
  - The credit should be refundable, in order to help low-income taxpayers.
  - Ways to make the credit advancable should be explored.
- If a voucher is used:
  - The voucher amount should be based on an objective measure of the cost of providing health benefits, and should represent roughly 60-75% of the cost of coverage (e.g., equal to 75% of the national average Federal Employee Health Benefit Plan (FEHBP) premium).
  - The voucher should be adjusted for geographic and demographic variations in cost.
  - The voucher should be redeemable by health plans for actual premiums up to the full face-amount and electronic assignment of vouchers and transfer of funds would be encouraged to facilitate administration.

III. GUARANTEEING ACCESS TO COVERAGE FOR UNINSURABLE INDIVIDUALS THROUGH STATE HIGH-RISK POOLS

Conceptual approach: Authorize broad-based federal funding to encourage states to guarantee uninsurable individuals (those who would not qualify for private, medically underwritten individual policies) access to coverage through high-risk pools. While some states have chosen to implement other mechanisms to guarantee access to coverage, guaranteeing access to coverage through high-risk pools should be the preferred approach. Financing for high-risk pools at both the state and federal levels should be provided through broad-based funding.

Target population: Individuals who may be able to afford to pay a meaningful premium, or have a voucher or other subsidy available to pay a premium, but who do not qualify for private coverage due to health status.

Key elements of the proposal:

- Provide federal seed money to states without high-risk pools for start-up costs (program design and administration, initial reserves, outreach, etc.).
- Provide federal block grants for all states to defray administrative costs of high-risk pools.
- Provide 50-50 federal matching funds for the underwriting losses of pools (claims minus premiums). However, if a pool sets premiums below 150% of a standard private market rate, the match will be calculated as if the premiums were set at 150% of standard.
- To receive funds, state pools must have lifetime maximum benefits of no less than $1 million, and meet NAIC model high-risk pool standards.
- Federal reinsurance program for qualifying state high-risk pools will cover 75% of claims over $1 million for an individual pool enrollee (indexed to medical CPI).
- The Secretary of Health and Human Services (HHS) will establish pools in states if the state has not sponsored a pool (federal funds will be matched by withholding appropriate federal matching funds in such states).
- Any new state or federal funding for this program must be stable and broadly-based.
- States should replace guaranteed issue and community rating requirements in the individual health insurance market with guarantee access through high-risk pools

IV. ENCOURAGING GREATER COVERAGE FOR INDIVIDUALS AND SMALL BUSINESSES THROUGH ENHANCED TAX INCENTIVES

Conceptual approach: Provide a variety of additional tax subsidies, in conjunction with targeted consumer education, to encourage more individuals and employers to purchase private health insurance.

Target population: The self-employed, small businesses, and individuals without access to employer-sponsored health insurance coverage.

Key elements of the proposal (employer market):

- Small employer tax credit (could be phased-in beginning with smallest employers). To be eligible for the credit, a small employer must have an average payroll below the median for all small firms.
  - 40% credit for employers with fewer than 10 employees
  - 25% credit for employers with 10-25 employees
  - 15% credit for employers with 26-50 employees
- Allow employee contributions for health insurance to be excluded from taxable income (even if not made through a section 125 cafeteria plan)

Key elements of the proposal (individual market):

Allow all individuals, not just the self-employed, to deduct the full cost of health insurance premiums.

- Undertake a variety of consumer education and outreach activities on the importance of having and maintaining health insurance.

V. ENCOURAGING INCREASED COVERAGE AND PROVIDING MORE OPTIONS FOR CONSUMERS BY EXTENDING AND ENHANCING ARCHER MEDICAL SAVINGS ACCOUNTS (MSAS)

Conceptual approach: Encourage more individuals and employers to purchase health insurance and save for future medical expenses by extending and enhancing Archer Medical Savings Accounts (MSAs). Increase the number of Americans who are given the option of establishing an MSA, and enhance the program to better meet the needs of the average American consumer.

Target population: Individuals and business of all sizes.

Key elements of the proposal (Medical Savings Accounts):

- Make MSAs more attractive by simplifying rules
  - Extend eligibility to large employers
  - Extend eligibility to all individuals—not just the self-employed
  - Eliminate sunset provision
  - Allow both employee and employer contributions to MSA account
  - Allow cafeteria plans to offer MSAs
  - Allow imbedded individual deductibles with family deductible cap
  - Increase the deduction allowed for MSA contributions to 100% of the deductible amount under the qualifying high deductible insurance policy
  - Increase the range of allowable deductibles and out-of-pocket limits (Lower limits are important to allow MSA holders' to limit their liability as they accumulate funds for medical expenses, and higher limits are important for policyholders who have accumulated, or expect to accumulate, significant funds in their MSAs).
  - Make it easier for PPOs and other network plans to offer MSA products
  - Preempt state benefit mandates to the extent that they would require a qualified high-deductible health plan to provide coverage below the level of the deductible. If this is not acceptable, then qualified high deductible health plans should be allowed to provide low-deductible or first-dollar coverage when necessary to comply with a state benefit mandate.

COST AND ACCESS TO AFFORDABLE COVERAGE

InsureUSA, through a combination of targeted subsidies for low-income individuals, federal matching funds for risk pools for individuals with serious medical conditions, and enhanced tax incentives to encourage the purchase of health insurance, addresses the need to ensure access to coverage to all Americans. But meaningful efforts must also be taken to reduce the cost of health care and make health insurance coverage more affordable. Costs must be addressed in three broad ways. First, regulatory burdens that increase the cost of coverage must be reduced. Second, individuals must take greater responsibility for ensuring that the health care they receive is paid for, and thus for ensuring that they have the health care coverage they need to fulfill that responsibility. Third, individuals must become more careful consumers of health care through increased control over and an increased financial interest in health care purchasing decisions.